




THE BRITISH  
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VOL. XVI.



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# THE BRITISH GYNÆCOLOGICAL JOURNAL

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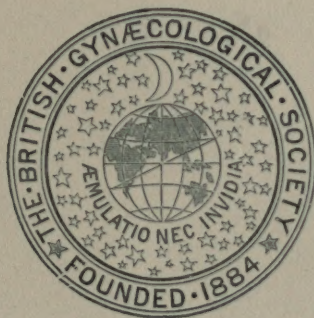
*THE BRITISH GYNÆCOLOGICAL SOCIETY*

VOL. XVI.

EDITED BY

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# THE BRITISH GYNÆCOLOGICAL JOURNAL.

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*BRITISH GYNÆCOLOGICAL SOCIETY.*

THURSDAY, FEBRUARY 8, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

UTERINE MYOMA ASSOCIATED WITH TEMPORARY GLYCOSURIA AND UMBILICAL HERNIA; SUBPERITONEAL HYSTERECTOMY AND RADICAL CURE OF HERNIA; RECOVERY. By ARTHUR E. GILES, M.D., B.Sc.Lond., F.R.C.S.Ed., M.R.C.P.Lond., Assistant Surgeon, Chelsea Hospital for Women; Gynæcologist to the Tottenham Hospital.

IN October, 1899, I saw Mrs. V. in consultation with Dr. A. S. Gubb, who, in examining an umbilical hernia, discovered a large uterine fibroid reaching to within two fingers' breadth of the umbilicus. Her principal symptoms were menorrhagia and frequency of micturition. She was aged 48, and had had one child, now aged 12. Menstruation had been increasing in quantity for some years, and had been increasingly abundant during the last eighteen months, leaving her hardly ever free.

Examination confirmed the diagnosis of uterine myoma ; the tumour was the size of a pregnant uterus at the fourth month, and nearly filled up the inlet of the pelvis. In view of the present symptoms, the presence of the umbilical hernia, and the risk of impaction of the tumour in the pelvis, I concurred in the view that hysterectomy was indicated, this operation allowing me to procure the radical cure of the hernia as well. She was placed in a home, and on examination of the urine, Dr. Gubb found that sugar was present amounting to 5 per cent. She had neither thirst nor polyuria, and the glycosuria was quite recent, since a short time previously Dr. Gubb had found the urine normal. Moreover, there was no wasting, but, on the contrary, the patient was a stout, florid woman with very fat abdominal walls. We therefore decided that the sugar did not mean diabetes, but was probably of functional origin, due to the nervous apprehension of the operation manifested by the patient. Under the circumstances I did not regard the glycosuria as a contra-indication to operation. On November 3 I performed a sub-peritoneal hysterectomy. The incision was carried up above the umbilical hernia, which was first dealt with by excision of the sac, and the uterus was then removed in the usual way. The operation was rendered rather difficult by the thickness of the abdominal walls, but otherwise presented no special features. The ovary and tube were left on one side. Recovery was uneventful, and the patient left the home well, three weeks after the operation. Sugar persisted in the urine for a week after operation, and then disappeared. It has not reappeared since.

I do not know of an instance in which a uterine myoma has been recorded as complicated with glycosuria ; the association of glycosuria with ovarian tumours has been noted, and I may refer to an interesting case reported by Halliday Croom.<sup>1</sup> In that case the patient presented other

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<sup>1</sup> Halliday Croom, *BRITISH GYNÆCOLOGICAL JOURNAL*, vol. ii., p. 476.

symptoms of diabetes, and the condition was regarded by Halliday Croom as being due directly to the presence of the tumour, by pressure, disturbing either the pancreatic functions or the hepatic circulation. I do not think that in my case the glycosuria was due in any way to the tumour, for two reasons, first, because the sugar in the urine was of quite recent occurrence ; secondly, because in that case one would expect glycosuria to be more frequently found with large myomata.

This case shows that glycosuria is in itself no contra-indication even to so grave an operation as hysterectomy. Wallace has recently shown<sup>1</sup> that it is in many cases a positive indication for operation in cases of gangrene. He regards the glycosuria as due in these cases to a septic process ; and believes that many cases of chronic sup-puration are on the verge of glycosuria. If these various views be correct, then, in addition to the usually accepted causes for glycosuria (pancreatic or hepatic disturbances) we may put down pressure of tumours (Halliday Croom), septic absorption (Wallace), and functional nerve disturbance, as in my case.

Dr. WILLIAM TRAVERS observed that the glycosuria in this case was probably functional. He would like to ask what were the symptoms that called for the operation of hysterectomy, apart from the presence of the glycosuria, since apparently the latter was in no way due to the tumour. At the present time, when the question of operation for fibroids was being largely discussed in the medical press, it was very important to know the reason for operation in each case.

Dr. MACNAUGHTON-JONES said that though a relationship between ovarian tumour and diabetes or glycosuria had frequently been noticed, it was not so with regard to myoma of the uterus. Post-operative glycosuria was not uncommon, and after ovariectomy its disappearance had been

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<sup>1</sup> Wallace, *Lancet*, December 23, 1899.

explained by the emptying of the large veins and a consequent anæmia of the liver, as interference by pressure with either the portal or the hepatic artery might cause it. In the case of the uterus it was different. In ovarian tumour there might be pressure on the pancreas, but these causes were not present in the case of a myoma unless it were of an exceptionally large size. In Dr. Giles' case he should regard the glycosuria either as a coincidence or as a result of a reflex nerve irritation, and that there was here no relationship as of cause or effect.

Dr. HEYWOOD SMITH agreed with Dr. Giles that the glycosuria in this case was probably due to impression on the patient's mind ; although it was to be remembered that pressure effects might result from even a relatively small tumour.

Dr. W. H. BOURKE asked whether in this case the glycosuria was quantitatively estimated ?

Prof. W. JAPP SINCLAIR (Manchester) observed that there were many points in this case in which more facts were desirable : for example, the amount of urine passed during the time that glycosuria was present ; the relation of glycosuria to meals, and the time of day, &c. On what grounds did Dr. Giles say that the case was not one of diabetes ? In his experience, when sugar had been constantly present in the urine, the patient had always died.

Dr. INGLIS PARSONS said that it was a matter of some importance whether the patient was very stout or not. There was a stout type of women who had glycosuria, not because of the existence of diabetes, but because of the dietetic habits. In a case of true diabetes, the condition would be a bar to operation. He judged that Dr. Giles' patient came under the first category.

Dr. GILES, in replying, said that the case was not one of diabetes, since there was no thirst, polyuria, or wasting. He regarded the glycosuria as of purely nervous origin, and as in no way related to the presence of the tumour. His main purpose in reporting the case was to show that



glycosuria was in itself no contra-indication for operation. In reply to Dr. Travers, the grounds for interference in this case were menorrhagia and pressure symptoms. As would be seen from the specimen, the tumour was just about large enough to fill up the pelvic inlet.

CASE OF A VERY DISTENDED PYOSALPINX OF THE RIGHT SIDE, THE OPPOSITE TUBE DISTENDED AND THICKENED, UTERUS REMOVED BY SUBPERITONEAL METHOD. RECOVERY. By F. A. PURCELL, M.D., M.Ch., Surgeon to the Cancer Hospital.

E. C., from Newport, Mon., aged 36, married, was admitted to the Cancer Hospital on August 28, 1899, complaining of a lump in the lower abdomen, causing great pain. She had not been well for thirteen years. Her mother died of cancer.

About thirteen years ago she had a yellowish discharge from the vagina, accompanied by great pain in the womb, for which she sought treatment at the Winchester Hospital for eight weeks. She was told there that the womb was prolapsed and was given an instrument to wear. Three years later the same thing happened and she returned to the hospital for seven weeks; she was unable to wear the instrument. Seven years ago the same occurred in India; again three years ago, and every winter since. She now complained of great pain and swelling in the pelvic region, menses irregular in time and quantity during last six months, as occurred during previous attacks; frequency and difficulty in micturition; urine, sp. gr. 1014, acid, no albumen; tongue furred, dyspeptic; bowels constipated, defæcation painful, except with liquid stools, abdomen not distended, muscles held rigid, tender on pressure.

*Per Vaginam*.—A tumour could be felt in the pelvis, pushing the cervix against the anterior vaginal wall; it could not be isolated from the uterus. *Per rectum*, the tumour



was felt impacted in Douglas' pouch and undoubtedly cystic. On consultation laparotomy was decided upon.

*Operation of Salpingo-hysterectomy, September 27, 1899.*—Having been duly prepared she was anæsthetised by means of gas and ether, the abdomen was opened between the umbilicus and the pubes to the side of the linea alba, through the fibres of the rectus muscle; the patient was then raised into the Trendelenburg position, and a large fluctuating tumour was found occupying the right side of the pelvis, being about the size of a foetal head of six months' gestation. It was firmly agglutinated to the side of the uterus; old-standing adhesions with thick organised lymph bound down the cæcum, and the uterus, of normal size, was pressed over to the left; the left tube lay much enlarged and thickened, bound down with organised lymph. The cæcum was freed, and in tracing the appendix it was found bound down and stretching across Douglas' pouch to the right, three inches long and attenuated; this was freed and removed. An attempt was made to enucleate the tumour, but it was found impossible to separate it from the uterus; in the manipulation the cyst burst, and gave exit to a large quantity of thick pale pus; some escaped into the abdominal cavity. Total removal of the uterus was then decided upon and carried out by the subperitoneal method; an iodoform gauze drain was passed down the canal of the cervix and os into the vagina; the sigmoid flexure rose up behind the uterus, hard and tense and resembled a fibroid, but was recognised as intestine; the stump of the cervix was not sutured together, no blood was lost; the pelvic peritoneum was carefully stitched across with catgut. The abdomen was then freely flushed out with warm saline fluid, some gallons being used, to wash out the pus that had escaped. No drain was inserted beyond the gauze already mentioned; a single row of silk-worm gut sutures was used to unite the abdominal wall. Patient made a good recovery, and left hospital much improved in every way, looking stouter than when admitted.

The specimen presents a large sac now much contracted from the spirit solution, so that its size *in situ* can hardly be surmised. After removal it was found to be impossible to free it from the side of the uterus. The opposite tube is to be seen enlarged and thickened; the ovaries were allowed to remain. The question I should much wish answered is, was it feasible to enucleate the sac? And was I justified in removing the uterus?

Prof. JAPP SINCLAIR remarked that if it was justifiable in this case to leave the ovaries, they must have been healthy; and if the ovaries were healthy, whatever the condition of the tubes, the best operation would have been vaginal incision and drainage.

Mr. FURNEAUX JORDAN considered that the treatment to be adopted depended largely on the condition of the tube of the other side, for unless there was much disease of the other tube, he did not think that they would be justified in removing the uterus. When the adhesions were so great that they could not be separated, it was better to incise through the vagina and drain. In such cases there was always a history of repeated attacks of peritonitis, and this would lead to a correct diagnosis. He did not see how it could be necessary to remove the uterus. It was all very well to say that the uterus was no good; but even if the woman could neither bear children nor menstruate, he still saw no advantage in removing the uterus as long as drainage was possible. He would make an exception in a case where the sac burst, and it could not be removed without removing the uterus. In any case he thought that the vaginal route was the best.

Dr. MACNAUGHTON-JONES said that as Professor Japp Sinclair and Mr. Furneaux Jordan had spoken against removal of the uterus in cases of extensive pyosalpinx, it might be well to hear a word on the opposite side of the question. At the International Medical Congresses it was incontrovertible that the majority of continental and American authorities had decided in favour of salpingo-hysterectomy

in cases of pelvic suppuration and double pyosalpinx, and the same might be said of the International Gynæcological Congresses. In the route by posterior colpotomy the complete removal of such suppurative adnexa was often most difficult, if not impossible. Salpingo-hysterectomy in such cases, without materially increasing the risk, facilitated the complete removal of the diseased ovaries and tubes. In abdominal cœliotomy, which in such adherent cases he himself would prefer, he believed also that salpingo-hysterectomy was the right operation to perform. While the disadvantages of leaving the uterus were apparent, the advantages were most doubtful, for it should be remembered that in these cases the uterus was frequently the starting-point of the disease, there had been old endometritis, and in a large proportion of the cases, gonorrhœa was the source of the mischief. He failed, therefore, to see the gain to the woman of leaving an unhealthy and useless organ.

Dr. INGLIS PARSONS thought that Mr. Furneaux Jordan spoke to the point when he said that if one side was healthy the uterus should not be removed. He preferred the abdominal route for dealing with pyosalpinx; at the Chelsea Hospital for Women they had found that in nearly all cases the contents of a pyosalpinx were sterile; and if a little pus escaped during the operation, it did not much matter. Certainly the possibility of this accident was no contra-indication to operating through the abdomen.

The PRESIDENT said that his view was in favour of removing the uterus, because when both sides were so much diseased as in this case the uterus was also diseased; and if it were left, the patient was not cured. The pus in the tubes were not always sterile; he had found cases where it was otherwise.

Dr. PURCELL, in reply, said that if he had attacked this case by the vagina he would have got into great difficulties owing to the bowel adhesions; and the case would probably have ended fatally. The balance of opinion in the Society seemed to be that in the case of double tubal

disease with uterine adhesions it was safer to remove the uterus as well. Time would show whether it was judicious to leave the ovaries in this case.

Dr. PURCELL also showed a card specimen of a fibromyoma of extraordinary shape, springing from the uterine fundus. It was a sausage-shaped mass, ten inches long and of the thickness of a man's wrist ; in its fresh state it resembled a stunted cactus plant. It was removed by subperitoneal hysterectomy from a nulliparous patient, aged 40, on January 10, 1900. Convalescence was afebrile and terminated in recovery.

#### CASE OF CHRONIC TOTAL INVERSION OF THE UTERUS.

By F. WINSON RAMSAY, M.D., F.R.C.S.Ed., Bournemouth.

L. S., married, aged 48, was admitted to the Royal Victoria Hospital, Bournemouth, December 28, 1898, suffering from incontinence of urine and chronic uterine trouble.

*History.*—Always well and healthy ; had several children, last child born fourteen years ago ; had normal labour, but the doctor had to peel off the placenta. Three days after labour had castor oil, and while on the bed-pan the uterus came out into the pan. Doctor arrived within three-quarters of an hour, pushed it back into vagina, and kept it there with a pad and bandage ; no excessive hæmorrhage. Seemed to have a swelling inside vagina, which gradually felt better ; was able to get about and do some work, but from that day has always had a little bloody discharge. About twelve months after consulted a doctor, who introduced a Zwanck's pessary, which gave some relief ; patient took it out once a week for cleaning. In March, 1898, a larger pessary was given her, and as she still complained of pain in back and bearing down, she was told not to take it out so often. In May, 1898, patient noticed that the water was always running away from her.

In September, 1898, patient was unable to remove the



pessary. The doctor told her it was covered with a deposit of gravel, and it had to be broken in pieces and removed under chloroform. After removal of the pessary water ran away more than ever.

*Examination.*—Revealed at once a completely inverted uterus, not much larger than a normal uterus, and covered with stinking slime and phosphates; the base of the bladder was completely gone, exposing the fundus, and the edges were composed of a ring of dense cicatricial tissue. After rendering as aseptic as possible, uterus was removed with a pair of scissors on January 3, 1899. Operations for closing fistula February 18, March 22, April 11, June 13, July 12, August 15. After operation required to empty bladder about every half hour. Now quite well, does all her work, can go easily three hours every day, and never gets up at night. Expect further improvement still.

Dr. CLEMENT GODSON thought that there was no doubt that Dr. Ramsay's treatment of this case had been good throughout. It would have been useless to try to restore the uterus, in view of the condition of the bladder. Had there not been a vesico-vaginal fistula it might have been possible to reduce the inversion by means of Aveling's repositor, since this could be effected when an inversion had existed for many years. He had on several occasions restored such a uterus. Zwanck's pessary should never be allowed to remain *in situ* for any length of time, but should be removed every night and replaced in the morning. He had often used this pessary at St. Bartholomew's with good results in old women suffering from procidentia who would not undergo any operation.

Dr. MACNAUGHTON-JONES said that Dr. Ramsay deserved their warmest congratulations on the issue of a case which was one of the most difficult to effect a cure in, and for the originality of the idea of closing so large a vesical opening by transplantation of the vagina and implantation of the uterus. The first who so utilised the uterus by the supra-pubic method was Dittel. Martin had formed a floor



for the bladder with the vaginal tissue, and Howard Kelly's operation was very much the same as that mentioned by Dr. Ramsay. A Zwanck's pessary, unless carefully disinfected from time to time, and regularly removed for cleansing, was simply a mechanical contrivance for the incubation of septic filth in the vagina.

Prof. W. JAPP SINCLAIR related a case in which he found a vesico-vaginal fistula in a patient who gave a history of forceps delivery. There was considerable loss of tissue; and it seemed to him that the only thing to do was to turn the uterus itself into the bladder. This he did, and the patient thereafter went on menstruating through the bladder without any inconvenience. This showed that the surface of the uterus, as well as that of the vagina, need cause no bad results when turned into the bladder.

Dr. JAMES OLIVER thought it hardly possible that a woman with complete inversion of the uterus could have worn a Zwanck's pessary in the manner in which and for the length of time that this patient did; it was difficult to say when the inversion could have occurred in this case, but it might have happened when the pessary was removed. He had in one case removed an inverted uterus from a patient, aged 55, where it was the result of a small myoma, and had been suddenly induced at that advanced age.

Dr. RAMSAY, in reply, said that for the history of the case he had to depend entirely on the patient's statements; his own view was that the inversion had been present all the time, but he had some doubts on the subject, because she had seen several doctors who apparently did not diagnose that she had an inversion of the uterus.

## PRESIDENT'S INAUGURAL ADDRESS.

INSTRUCTION IN OBSTETRICS AND GYNÆCOLOGY. By  
W. J. SMYLY, M.D., T.C.D., F.R.C.P., President of  
the British Gynæcological Society; Gynæcologist to  
the Adelaide Hospital, Dublin.

In this country, curiously enough, practical instruction in midwifery is generally of a most primitive description, owing chiefly to the paucity of well-equipped Lying-in Hospitals, and this is the more remarkable since in comparatively insignificant towns on the Continent there are splendid Maternity Hospitals, superior to any to be found in this country, where the students are carefully instructed by professors of great learning and experience, assisted by an efficient staff of assistants. Clinical teaching can only be carried out efficiently in the wards of a hospital, but most of our students pick up what they can from attending a few women in their confinements in their own homes. What would be the position of medicine and surgery in this country if the only instruction given to students were a course of systematic lectures, and a few domiciliary visits with or without the assistance of their teachers.

As regards gynæcology the case is different. All our large hospitals possess a gynæcological department which, together with special hospitals, afford ample material for the practical study of women's diseases. These departments are well equipped and supplied with competent teachers, but the benefit which would otherwise be derived is nullified by the unpractical nature of the examinations. To the majority of students the chief object of study is to pass their examinations; to the diligent and ambitious to do it with credit, and rightly because their position in after life mainly depends upon their doing so. A student is well aware that in passing through that ordeal he will be brought to the bedside, and will have to diagnose the disease from which the patient is suffering. He cannot

tell what part of the human body he may be called upon to investigate, but of one thing he is certain, that it will not be the female pelvic organs. He must therefore familiarise himself with the methods of examination in every other department of medicine and surgery, but the practical study of women's diseases he may safely neglect. I have found this in my own hospital work. My clinical lectures are well attended by the students, the examination of patients badly, and the operations hardly at all. I do not suggest that every student should have a practical examination in midwifery and gynæcology, though in other countries this is the case; in the McGill University, for example, a clinical examination in these subjects similar to that held in medicine and surgery, forms part of the final examination; but I do think that he should take his chance of such an examination, and it appears to me an anomaly that every student has to submit to a practical examination upon the eye, and no student is examined in this way upon the uterus. And this is the more remarkable because in no other branch of medicine is practical knowledge relatively more important than in this. The theory of midwifery and gynæcology is a limited subject and easily acquired, but the practical manipulations are exceedingly difficult and require much time and trouble. A practitioner who has passed his examinations with a minimum of knowledge can easily supplement it afterwards by study, but the *tactus eruditus* can then only be acquired after much discredit to himself and possible injury to his patients.

#### *Midwives and Monthly Nurses.*

The education of midwives has received a large amount of attention, but is still in a most unsatisfactory condition. It is a lamentable fact that after upwards of a century of agitation nothing has been done to enforce women who undertake to attend others in labour to have any knowledge at all of their duties. During the past quarter of a century

I have been brought much in contact with midwives, and as a class I have found them an honest, careful, respectable, and fairly efficient body of women. To this general rule, however, I have found exceptions, and have met with ignorant, drunken, and meddlesome women, who were a source of danger to their patients; and if this experience be multiplied by that of practitioners throughout the country, it represents a large number of ignorant, incompetent, and even immoral women. This is a condition of things which is a disgrace to our civilisation, and loudly calls for legislative reform. This question has before this been brought before our Society, and it is our duty, not only to press for reform, but so to influence the course of legislation that it may prove beneficial alike to the public and the medical profession. At the present time anyone may practise midwifery, and call themselves midwives. It should be our object to insure that in future only properly trained women should use this application, and that they should not overstep their duties by practising midwifery.

In an inaugural address as President of the Obstetrical Society in 1895, Dr. Champneys gave a clear and concise history of midwives in England, and the work of that Society in relation to their examination and registration, a history which could not be too widely circulated or too seriously considered by medical men in these countries at the present time. We should never forget, and we should not allow the public in the present agitation to overlook the fact, that this movement for reform originated with, and has ever since found its most ardent supporters among the members of our profession. In 1616 Dr. Peter Chamberlain begged James I. "that some order may be settled by the State for the instruction and civil government of midwives." In his work, "*A Voice in Ramah*," he speaks thus:—"Because there was never any order for instructing and governing midwives, therefore there never must be; because multitudes have perished, therefore they still must perish; because our forefathers have provided no



remedies, nor knew any, therefore we must provide none, though we know it." "These words," Dr. Champneys says, "are unfortunately as true to-day as when they were written." In 1756, through the influence of Dr. Mosse, the Rotunda Hospital was incorporated by Royal Charter, and one of the chief objects named and reasons assigned for granting that Charter was "that by admitting and instructing in such hospital women who, after some time spent there, being duly qualified, may settle in such parts of our said kingdom as most stand in need of such persons, it will be a means of preventing the unhappy effects owing to the ignorance of the generality of country midwives. That by preserving the lives of so many infants who in all probabilities must otherwise perish, it will increase the number of our subjects in our said Kingdom." In 1813 the Society of Apothecaries, in 1882 the British Medical Association, in 1890 the Midwives Institute, the Obstetrical Society and British Medical Association urged upon Parliament the necessity for legislation. A Select Committee of the House of Commons in 1892-93 recommended that a system of examination and registration of midwives should be established. I need not recall all the efforts made, and bills brought forward, but hitherto in vain, to cure what all admit is a deplorable evil.

The chief causes of past failures are, I believe :—

- (1) The apathy of the general public.
- (2) The opposition of a large part of the medical profession.
- (3) The exclusion of Ireland from all bills hitherto framed.
- (4) The difficulty of carrying any private bill through Parliament.

The first cause of failure is slowly but certainly being removed. A sudden disaster, such as a shipwreck or a reverse in war, at once attracts public attention, but constant and long-established evils such as tuberculosis and puerperal mortalities are more difficult to bring into

public notice, though the total loss of most valuable lives be infinitely greater

The opposition of a large number of the medical profession demands most careful consideration, but it is, I think, on the wane, as practitioners come to see that something must be done. The cry that midwives should be ended, not mended, and that every woman should be compelled to call in a fully qualified medical attendant is absurd and impossible, and the methods adopted against those who are endeavouring to improve the education of midwives have only brought discredit upon their authors. In Dr. Champneys' address, already referred to, he said "some men sometimes waked up and found themselves famous," so the London Obstetrical Society found themselves (nearly but not quite, and in a strictly professional sense) infamous. A similar charge of infamy in a professional sense was at the same time brought against myself and the Master of the Coombe Hospital, and for the same reasons, namely, that we had been guilty of doing what we were authorised by Royal Charter to do, and what my predecessors had done with great benefit to the public for upwards of a century, examining and granting certificates to midwives and monthly nurses. And these gentlemen carried this matter so far as to humbly pray the General Medical Council to remove our names from the Register of Medical Practitioners. Yet there is behind this burlesque a wide and serious feeling that the State recognition of midwives would be detrimental to the interests of the medical profession, and would create a new order of medical practitioners. This fear it would be folly to ignore.

It is due in the first place to experience ; such a class, for it is destitute of order, does exist, and does much harm. It has existed from all time, and only comparatively recently have medical practitioners invaded its domain, yet at the present time a large and increasing number of women seek the aid of medical practitioners, and this is because they have come to appreciate the value of such assistance, and

I think what Virchow has recently said with regard to quacks applies to midwives, especially the untrained and ignorant. "No penal law would succeed in driving those who seek aid from *midwives* to regular practitioners. This can be hoped for from better education and greater enlightenment of the masses." Since, then, this class does exist it is idle to talk of its creation, and it would be better were all to endeavour to improve it and confine its sphere of action within safe bounds than to offer an unbending resistance to all measures of reform.

Another cause for this feeling of distrust on the part of medical men is the definition of a midwife as a person who is to attend natural labours without the aid of a medical practitioner. In England you make a sharp distinction between midwives and monthly nurses. The former undergo a longer training and severer examination, and naturally regard themselves as superior to the latter. This, I think, is unfortunate, as the midwife might consider it as degrading herself to the condition of a monthly nurse were she to seek the aid of a medical man; and that this is not a merely theoretical objection I can prove from the experience of a friend who practises in the south of England, who was sent for by a midwife to a case of placenta prævia, but no sooner had he arrived than she immediately departed, leaving him to face a very serious situation alone and unassisted. This distinction is not only injurious, but is artificial, and impossible to carry out in practice. Should a midwife meet with a complication, as in the case to which I have alluded, she should not only send for assistance, but she should remain and assist as a nurse. A monthly nurse, on the other hand, may not be able to secure the presence of the medical attendant at the time of the birth, and she then becomes a midwife, and should have been trained as such. In Ireland we make no such distinction, and midwives are generally ready to call in medical assistance. That this is a matter of importance has been proved by the agitation for the registration of

obstetric nurses instead of midwives. Personally I can see no objection to the retention of the name midwife, but I do see serious reasons for abandoning the definition that she is qualified to attend without a medical practitioner. It has been urged that it is impossible to define natural labour. This may be so, but there is no practical difficulty in defining the conditions under which assistance is to be obtained. Anyone who has had the management of an extern maternity attended by medical students or midwives has had to overcome this difficulty, and has found that a few printed rules with salutary warnings as to punishment to be inflicted in case of neglect is all that is required. In the Rotunda Hospital the student is warned that if he fails to comply with the rules, and especially if he fails to send for assistance under certain well-defined circumstances, he will be liable to expulsion, and his certificate withheld. In the case of a midwife the fear of having her name removed from the *Register* would, I believe, insure her sending for assistance under similar circumstances. In the reports of the Rotunda Hospital there are lamentable examples of cases sent into hospital too late to save life, but in my experience such neglect was the result rather of ignorance than malice, and I believe that many untrained midwives fail to send for assistance because they are unable to recognise the necessity for it. Education should precede registration, but under existing circumstances I fear we shall have to use registration as an inducement to improved education.

Now as regards our attitude in Ireland, we are strongly opposed to any measure for protecting the appellation "midwife" from which we are excluded. We have for many years educated a large number of midwives, many of whom practise in this country, and we believe that if these women were obliged to come over here to be examined and educated, the expense of travelling and living would be so great as to deter the majority from coming to us; we therefore consider it unreasonable that you should



expect us to burn our own fingers in pulling chestnuts out of the fire for you. Whatever our private opinions may be, like yourselves we are unanimous in opposing any measure which we consider will injure our Midwifery School, but why should we be excluded? Do we not suffer from bad midwives just as you do? If English mothers require protection, do not Irish just as much? But as a mere matter of policy I cannot understand why those who are anxious to pass such a measure should array against it the entire strength of the Irish Parliamentary representation.

After the delivery of the Address a vote of thanks to the President was proposed by the retiring President, who, in the course of his remarks, referred to the midwives' question, which was again before the profession. The Gynæcological Society had, he said, always approached it in a fair and liberal manner. They did not object to the enforcement of a systematic course of education for midwives, or, as he would prefer them to be called, monthly nurses, for he did not believe in the necessity, as others did, for the perpetuation of the term "midwife" as applied to unqualified women. Every medical practitioner was by law a midwife, and, since such qualification had become an essential part of a registrable diploma, without which the State permitted no one to practise medicine as a registered practitioner, there was the serious risk of confusion in the public mind as between two classes of midwifery practitioners. They had to consider the question from a tri-partite point of view, one part of which could not be separated from the other two, namely, the interests of the public, the profession and of the midwives themselves. He protested against any step which would dim the prestige or sully the traditions associated with the obstetric art, and he appealed to the President, looking back over the long and illustrious roll of obstetricians associated from the time of Auld, with his own school of midwifery, to say if it would not be unwise that with their eyes open they should take any step which might

in the least degree be retrogressive and impair those traditions and that prestige. The Gynæcological Society had last year approached the General Medical Council by a memorial on the subject and with regard to the present Bill, and had received from the General Medical Council a reply to the effect that the lines of that memorial were those upon which the Council had always proceeded, and which had actuated the steps which it had taken. Thus it was evident that the position of this Society was practically in accordance with the views of the General Medical Council. He congratulated the President on his position in the Chair of the British Gynæcological Society, which was proud of him as its President, representing as he did perhaps the most famous obstetric school in the world—the Rotunda Hospital of Dublin—of which he was a Past Master.

Dr. C. H. F. ROUTH, in seconding the vote of thanks, contrasted the teaching of gynæcology to-day with what obtained when he was a student. He admired the liberal and tolerant manner in which the President had discussed the midwives' question in the second part of his address. His own view of the matter was that they must have midwives, but that they should be put into their proper place.

The vote of thanks was carried by acclamation.

The PRESIDENT, in acknowledging it, said that one reason which induced him to bring forward the midwives' question was that in Ireland they had always refused to give any opinion on a Bill from which they were to be excluded. This was the first time that he had had the opportunity of speaking not simply as an Irishman, but as a Britisher.

## BRITISH GYNÆCOLOGICAL SOCIETY.

THURSDAY, MARCH 8, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

SOME CASES OF GYNÆCOLOGICAL SURGERY. By E. STANMORE BISHOP, F.R.C.S., Surgeon to the Ancoats Hospital, Manchester.

ACCURACY in diagnosis depends mainly upon the man who is examining, but however careful and accurate the observer, there remain some cases of abdominal surgery in which it would seem that it is only possible to reach a certain point before, and that the final diagnosis must be made either at or even after the operation. One learns more from one's own mistakes than from one's successes, and to others, the cases in which a fellow surgeon owns his limitations are always more interesting than those in which he was easily and obviously right from the commencement. I make no apology, therefore, for bringing before you my first three cases, which illustrate this point. The last two cases I show in order to bring up the question of comparatively early operation in uterine fibromyomata on which I am very anxious to elicit your opinions.

*Case I.—Sclerocystic Ovary—History simulating Ectopic Pregnancy.*—Mrs. H., aged 26, admitted October 18, 1899; two years previously, June, 1897, had the right Fallopian tube removed for pyosalpinx. Recovered perfectly. After this, she remained in good health until July, 1899, when she began to vomit, chiefly in the morning, but more or less all day, for a fortnight. Her breasts began to swell and

springe. About a week after, her menstrual period came on. This was at the proper time, but was much more than usual, and lasted six days. It was accompanied by expulsive "labour-like" pains. This has recurred with each succeeding period. The blood was passed in clots. When these passed the pain became easier. After the period in July, there was leucorrhœa persistently stained with blood until the next in August, which was somewhat less painful, and lasted three days. This was again followed by leucorrhœa until the next period in September. This period began and continued for one day, ceased for one day, and then returned for another twenty-four hours. With this period there was much more pain and vomiting than before. Shreds of membrane are said to have been passed on this occasion. Since the last period, October 5, she has been vomiting after nearly all food taken.

There is persistent pain in the left inguinal region, increased on micturition and defæcation. The abdomen is full, but not distended. There has been some pain over epigastrium for many years, but this is increased since the commencement of the present illness. The breasts are flabby, nipples have brown areolæ, with one or two follicles. Patient believes herself pregnant. The uterus is normal size and mobile. The right broad ligament is clear. On the left side is an elastic swelling, separable from the uterus, but attached to the broad ligament. It is approximately the size of an egg. Diagnosis was ectopic pregnancy. On October 20 abdominal section was performed in the Trendelenburg position. There were a few fine adhesions, easily separated, and two stronger but narrow bands attaching the mass respectively to the omentum and small intestine. These were tied and divided. The swelling, consisting of the left tube and ovary, was first separated from the uterine end, which was free for about one centimetre. The tube passed over and encircled the main mass. The whole was easily removed, not being firmly adherent to the broad ligament. The abdomen was closed by tier suture without drainage. Perfect recovery.



At the time of her next period, however, there was some pain on her left side, lasting two days, similar to that felt before ordinary menstruation, easily relieved by manganese, and which did not return.

Examination of the specimen at first appeared to confirm the diagnosis. An outer coat of moderate toughness, about 2 mm. thick, smooth externally, but villous internally, was incised, and turned up. It was free for about half its internal circumference. To the rest was intimately attached a fine transparent membrane, over which minute vessels ramified. Between the two projected the edge of a dark red substance, which suggested placenta.

When, however, the finer membrane was cut through, the cavity exposed contained only about 5ij. of a clear slightly albuminous fluid, in which floated a small tag of fatty membrane, depending from a narrow attachment to the upper part of the cyst wall, at a point some distance away from what we had taken to be placenta. Microscopic examination of the wall of the cyst at various points disclosed no amniotic or chorionic structures, but the sections were simply through tubal and ovarian structures.

The explanation which to my mind appears most probable is, that the previous inflammatory condition in the pelvis had produced firm adhesions between the tube and ovary. When, later, cystic changes commenced in the ovary, the normal dilatation which would otherwise have occurred painlessly was obstructed by these adhesions. The hydrostatic force exerted upon these by the dilating cyst produced the sympathetic irritation, leading to the evolution of all the symptoms which misled us.

*Case II.—Double Papilloma of Broad Ligament.*—Mrs. L., aged 40, three children, no miscarriages, menstruation always painful before, pain passing off when flow established. Periods regular up to time of fall, since have occurred every fourteen days. Sent to me by Dr. Knapton, of Manchester, in 1898. A very stout woman. She presented a greatly enlarged and distended abdomen, which, when I saw her,

contained evident free fluid. Dr. Knapton, who had watched the case for several months, was, however, confident that at first this fluid had been contained in a capsule of some kind. He diagnosed an ovarian cyst, springing from the left ovary. In the middle of August, 1898, she tripped at the top of the stairs, and fell heavily on to the floor of the hall beneath. Acute pain was produced at once, and the size of the abdomen very rapidly increased. He believed, and so did I, that the ovarian sac burst at this time, the fluid becoming free in the abdominal cavity. She was tapped by me on November 21, 1898, when  $3\frac{1}{2}$  gallons of perfectly clear, yellow gelatinous fluid escaped. This confirmed our diagnosis. She was taken into a surgical home, and abdominal section performed, November 30, 1898. A large amount, several gallons, of this clear fluid was evacuated. You will note the length of time which had elapsed since the injury, at which we presumed rupture of the cyst had taken place. The peritoneum was perfectly healthy, but springing from the left broad ligament was this mass, which appeared to be the sac completely inverted and presenting a reddened villous surface to the peritoneal cavity, instead of the usual pearly-white smooth surface which, in this case, appeared as if inside the mass. The patient recovered rapidly and was perfectly well for some six months.

Were we right in our explanation of the sequence of events and the appearances presented on opening the abdomen? If so, the after history is difficult to understand. In August, 1899, she again began to enlarge. This time the point of departure and the locality of most pain was the right inguinal and iliac region. Enlargement was more rapid than on the previous occasion, her circumference at the umbilicus measuring 53 inches, and she was again operated on in the same way by abdominal section on November 2, 1899. On opening the peritoneum, once more the same clear, yellow, gelatinous fluid made its appearance and gushed out in great quantity. Several gallons were

collected, but a large quantity besides escaped. On the right side, springing from the right broad ligament, was a mass precisely similar to the one previously removed, and which I show. The ovary was found distinct from, and just by the side of this. No other mass was found in the abdomen, except a small growth which might have formed part of this mass, and become adherent to the back of the uterus. At all events it was closely adherent to the organ, and appeared to come away separately. One coil of small intestine was reddened and somewhat villous looking, but the left broad ligament from which the original growth was removed was normal, and the rest of the peritoneum, as far as could be seen, was the same. The abdominal cavity was washed out with saline solution until it returned clear, closed by tier suture, sealed with celloidin. No drainage. Perfect recovery.

It seems difficult to imagine that two cysts springing from opposite ligamenta lata should become inverted, since there was no accident this second time to account, as the first appeared to do, for such an incident. On the other hand, if, as I am disposed to believe, both these growths are papillomata, it is curious that the neoplasm did not recur at the seat of its previous ablation, but at the corresponding point on the opposite side, and that it grew to this size without apparently affecting the rest of the peritoneum.

Such papillomata are recorded by various writers, and they appear to hold a position midway between malignant and simple growths. Knowsley Thornton had a case which had remained free from relapse nine years at the date of publication. Lomer records a case in which two such tumours were removed, the size of both fists, leaving secondary excrescences scattered over the intestines, and the parietal peritoneum, yet four and a-half years after there had been no sign of return. Kelly, however, records a case, which improved greatly after a tentative operation, which had to be abandoned owing to the wide generalisation of

the growth, but died three years later, with the disease in an advanced state.

Pfannenstiel found sixty papillomata in 400 cases of ovariectomy; of these, twenty-nine were bilateral, and twenty-six located only on one side.

Most of the cases recorded are cystic papillomata, the papillary growth occurring on the inside of cysts, or growing through the walls of such cysts. It will be noted that in this case, at all events in the second growth, there is no evidence of any such capsule, the growth being of the shape and character of an enormous mushroom, springing from the edge of the broad ligament, its origin occupying the site of the Fallopian tube, which was not seen. Kelly figures a similar condition on one side, a series of mulberry masses hanging from a delicate pedicle attached to the Fallopian tube.

Bland Sutton figures a similar mass, which he calls a ruptured papillomatous paroöphoritic cyst of the ovary, but he says that not all such papillomatous growths in this situation arise from the paroöphoron. The second tumour removed apparently had no connection with the ovary at all. This organ was lying by its side and external to it.

Penrose says that the most popular view among American and English pathologists is that papillomatous cysts originate from remains of the Wolffian body. Coblenz says that they arise from the medullary tubules of Kolliker.

By the kindness of Dr. Fothergill I am able to show sections of the second growth and of the ovaries.

*Case III.—Large Pyosalpinx, the Symptoms of which simulated Appendicitis.*—Mrs. O. L., aged 28, married seven years. No children or miscarriages. Admitted January 24, 1900. Does not admit having suffered in any way since marriage. No discharge, no pain or smarting on urination. Says that her husband is perfectly well and always has been. Menstruation has always been regular, with an occasional intermenstrual period of five weeks.

Fourteen days before admission she was suddenly attacked



with pain in the right iliac region. This pain was increased by pressure upon a point somewhat below McBurney's point. There was some vomiting, and constipation, but she has always been constipated. Dulness on percussion extends upwards from Poupart's ligament to beyond the umbilicus and median line. Skin tender, not œdematous.

Patient is very stout, alcoholic appearance. Colour florid. Lies on her back with her knees drawn up. Complains of intense pain in the lower abdomen. Worst on the right side. Temperature 102°. Was seen by two physicians, who diagnosed appendicitis.

*January 24.*—Under chloroform the mass was felt to be large and too closely connected with the uterus to be due to appendical abscess. Besides, its outer limits could be defined. It was therefore diagnosed as pyosalpinx. It was too high up and fixed for vaginal removal.

Abdominal section was performed in the Trendelenburg position. A large opening, passing to the left for 2 inches above the umbilicus, was made just outside the central line. The omentum was found firmly adherent to a tense, elastic mass behind, and to the right of the uterus. This was tied and divided in front. An attempt was then made to lift up the mass, but in doing so some thickened omentum which had been plugging the fimbriated extremity of the dilated tube, tore away, and pus, thin and ichorous, escaped. The sac was allowed to empty itself on to sponges, and then separation was begun from the uterine side. The uterus was normal in size. The tube at its point of exit from the uterus was the size of a male adult thumb; was closely and firmly adherent to the side of the uterus and broad ligament. When all was freed, the mass was turned out, and proved to be a tubo-ovarian abscess the size of a small cocoanut, springing from the right side. On the left, a fluctuant mass the size of a small intestine, and somewhat resembling it, was freed from numerous adhesions and removed. This was the left tube, and with it was a cystic ovary. There were many long membranous adhesions attached to the

bowel, uterus, and other organs, and these were tied and removed. The abdominal cavity was dried out and closed; as the cavum Retzii had been widely opened during the various manipulations, a small drainage tube was left in it, and removed in forty-eight hours. It is very doubtful if the parietal peritoneum was not soiled by some of the pus, and a good deal of evidently infected omentum was removed. After the operation the patient was very restless and in pain, requiring  $\frac{1}{4}$  grain hypomorphia.

Calomel was commenced four hours afterwards, 3 grs. at first, repeated every hour for three doses. There was considerable hiccough for thirty-six hours. Recovery was delayed by a sharp attack of bronchitis, and a little suppuration in the abdominal wound, but there was no peritonitis, and she perfectly recovered at last.

*Case IV.—Sloughing Fibromyoma.* (Sent by Dr. Parkinson.)—Mrs. T., aged 65, married forty-three years, seven children, youngest 27 years; very severe confinements, always required forceps; last confinement complicated with placenta prævia; two miscarriages. There has never been any definite menopause; was regular up to 60; irregular discharge of blood since. She has lost blood more or less constantly for the last four years. Eight years ago an intra-uterine polypus was removed by another surgeon. Has had some offensive smell for about five years. In August, 1898, there was a very great loss of blood mixed with very offensive material. Bleeding has been more in quantity lately. Has lost appetite and flesh for some time. Nothing in family history.

*April 19, 1899.*—Patient is shrunken, with flabby tissues, looking fully her age. Vulva is excoriated by watery discharges from the vagina; these discharges smell most foully and suggest the odour of carcinoma.

Os uteri is widely dilated; discharge issuing from uterine canal is cheesy, foul smelling, mixed with brownish watery fluid.

Recto-bimanual examination demonstrates a very large

uterus with firm, hard, well-defined bosses. Uterus is mobile, both broad ligaments clear. Diagnosis, sloughing uterine fibromyoma.

Combined operation, commencing from below. The uterine canal was plugged with iodoform gauze, the lips of the os being sewn together over it. The bladder was separated for some distance, Douglas' pouch opened, and, the uterine arteries being tied, the lower segment of the broad ligament was separated from the uterus on both sides. In the Trendelenburg position the remaining separation was completed, but on seizing the uterus with Doyen's vulsellum forceps in order to lift it, the outer coat tore, giving exit to some putrid material. Fortunately, a large sponge behind the uterus prevented this from touching the peritoneum, and the operation being rapidly completed, the mass was removed. From the deeper portion of the broad ligament and the vaginal edges some rather persistent venous bleeding occurred, so that several forceps were required. As the patient was rapidly becoming collapsed, these were collected in a bunch, wrapped round with iodoform gauze, and left, projecting through the lower part of the abdominal wound, which was closed down to them, the gauze being previously drawn into the vagina, so as not to project into the abdomen, its upper extremity lying just below the level of the pelvic peritoneum. About four other forceps had been left on in the vagina; these were also wrapped in gauze, and the patient somewhat hurriedly transferred to bed, as the pulse was extremely low and thin.

After a short time she rallied, and in forty-eight hours the forceps were cautiously removed, the gauze being left for twenty-four hours longer. When this came away the track was covered by a dark, black, sloughy membrane. There was, however, no sign of peritonitis. The track which extended through from the abdominal wall to the vagina was mopped with strong carbolic acid and dressed with glutol, and two days later was gently irrigated with formalin solution. Under this the slough separated, leaving

a clean granulating surface. Healing was delayed by a certain amount of suppuration in the subcutaneous layer of the wound, into which the same black slough spread but after opening up the skin, washing out and dressing with glutol, this cleared up and the patient entirely recovered, although for some weeks she gave us considerable anxiety there being great difficulty in feeding her and a strong tendency to syncope, but there was no peritonitis from first to last. She has, as was to be expected, some ventral hernia, but no sinus, and the hernia is easily controlled by a belt. She reports herself February 23, 1900, as greatly stronger than for years, but with some slight difficulty at times in retaining urine.

*Case V.—Uterine Multiple Fibroma with Central Suppuration in one Mass, no Menorrhagia.* (Sent by Dr. Dreschfeld.) Mrs. H., aged 40, married, three children, all severe confinements, instruments with all. Healthy-looking woman. No menorrhagia. Sensation of weight, pain over coccyx, prolapse, nausea, and vomiting. Illness dates from birth of first child, nineteen years ago. Pain and sickness are intensified at the menstrual periods. Has worn a ring pessary for some years. This is shrivelled and offensive, and has produced some excoriation. Patient has become stouter, and rather breathless. Last period, January 9, very slight amount. Defæcation and urination easy, but amount of urine lessened. Examination shows an enlarged prolapsed uterus, very heavy, with hard rounded mass on the left side of fundus, and continuous with it.

*January 19, 1900.*—Abdominal panhysterectomy in Trendelenburg position. Left ovary and tube adherent, tense, enlarged, forming one mass, removed with uterus. Right tube enlarged, lengthened considerably, right ovary apparently normal, both left. On removal of uterus, pelvic peritoneum united over gauze drawn into the vagina from above, by continuous suture, which turns all raw surfaces into vagina. Abdominal wall closed by tier suture, and sealed by celloidin. No peritoneal drainage.



The uterus, when cut open, showed two main masses, one subperitoneal, without secondary change, one interstitial and submucous. In the centre of this was a necrotic cavity, containing thick pus. This, I think, is interesting, as showing the preponderating influence of proximity to the mucous canal over vascular supply in determining necrotic changes. The patient made an uninterrupted recovery.

This case is brought forward in conjunction with Case IV., because there were in it none of the symptoms usually considered as justifying operative interference. There was no great loss of blood, no loss of health, anæmia, or emaciation, no rigors or other signs of septicæmia. She was not confined to bed, or even to the house, and yet there was present a sloughing fibroid, which would within a comparatively short time have burst into the uterine canal, and no one could doubt but that, when this occurred, all the symptoms, risks, and dangers present in Case IV. would have manifested themselves. By timely removal these were avoided, and the patient preserved her health. Myomectomy would doubtless have removed the two largest masses, but after section of the uterus, numerous smaller masses were found developing, the presence of which was not detectable by touch or sight even after removal. These masses if left behind would, without doubt, have developed later, and necessitated further operative interference. Moreover, any attempt to remove this tumour except as a whole would have liberated pus, the infectiousness of which could only have been a matter of conjecture at the time of operation. The position I wish to maintain is that, whilst some fibroids, such as those discovered by accident, having given rise to no symptoms whatever, are best ignored entirely; whenever a fibro-myoma shows signs of growth it is wisest to remove it, and with it the organ in which it has developed—the uterus; the removal or otherwise of appendages to depend entirely upon their diseased or healthy condition.

Dr. MANSELL-MOULLIN, speaking of the difficulty of

diagnosis in Mr. Bishop's first case, pointed out that in many cases the diagnosis of extra-uterine gestation depended almost entirely on the statement of the patient; and the consequence was that no error arose more frequently than this one. In most cases where extra-uterine gestation was diagnosed the tumour was found to be a pyosalpinx. The error was, however, of no great importance, since the same treatment was required for both.

Dr. C. H. F. ROUTH said that in dealing with an abdominal tumour the conclusion was often come to that the swelling was solid or liquid; but the most conclusive test was generally omitted, which was this: that on listening with the stethoscope the sounds of the heart were not transmitted through a liquid tumour, whilst they were readily transmitted when the tumour was solid. The stethoscope ought, therefore, to be always used in making a diagnosis.

Dr. MACNAUGHTON-JONES said that the most important point raised by Mr. Stanmore Bishop was the question of early operation in the case of uterine myomata. It had been laid down as a surgical axiom, that if the risks attendant upon an operation were not in themselves greater than those arising out of the disease for which it was proposed to operate, then operation was advisable and justifiable. This appeared to him to be the issue in this instance. Were the risks from any given fibroid tumour greater than those arising from the operation in the case of the particular tumour on which it was proposed to operate? The present percentage of fatal results from supravaginal hysterectomy did not exceed in favourable hands from 5 to 8 per cent. When they came to consider the direct and indirect consequences of uterine fibroid, it would be seen that the risks arising from the disease were considerable. A certain number of patients contracted cardiac disease, a certain number died from ureteral and renal affections, another proportion succumbed from pelvic complications, some became affected by mental disease and dementia, and he instanced a case which he had lately seen where death

occurred from anæmia and septicæmia, the consequences of hæmorrhage and necrosis of the tumour. Besides such constitutional conditions as these, there were many collateral troubles which deteriorated the health of a woman who suffered from fibroma. Of course there were tumours which gave rise to no troublesome symptoms, and which no one would operate upon and in which operation would not be justifiable, but in the case of a growing fibroid and when the patient's life was threatened by any of the risks which he had mentioned, he thought that modern surgery emphatically declared itself in favour of operative interference.

Mr. BOWREMAN JESSETT congratulated Mr. Bishop on his interesting series of cases. The question of the early removal of fibroids was one of the greatest importance. Dr. Champneys had lately written a paper in the *Lancet* deprecating the operation because of its high mortality, which he put down at 17 per cent. When he read Dr. Champney's paper he was much surprised, because he thought the mortality was no more than 8 per cent. in skilled hands. It was, however, to be remembered, as was pointed out by Mr. Harrison Cripps, that some of the patients operated upon in St. Bartholomew's Hospital were already *in extremis*; such cases should not be included when estimating the mortality of the operation; but at least they supported Mr. Bishop's contention that myomata should be operated upon early. The mortality of the fibroids that were not operated upon was not known. For his own part, he advocated early operation. The question of age was of some importance; but if the patient were about to reach the menopause when the fibroid began to grow, this was an argument, not for delay, but for early operation. Mr. Jessett then related two cases in which the patient would clearly have died if not operated upon. As to the choice of operation, there was a time when he advocated panhysterectomy; but he had now become a convert in many cases to supravaginal hysterectomy, per-

formed in the manner first carried out in England by Dr. Heywood Smith.

Dr. HERBERT SNOW said that he remembered seeing, in the pre-hysterectomy days, a woman with a very large fibroid, which grew slowly for over twenty years, when the patient died. At that time the tumour weighed about 24 lbs., and death resulted from pressure. At the autopsy it was found that the tumour was firmly incorporated with the soft tissues of the pelvis all the way round, and it contained several foci of suppuration. Such cases were an argument in favour of early removal.

Mr. CHARLES RYALL, referring to Mr. Bishop's case in which forceps were left on, remarked that he had never left forceps on after a hysterectomy without regretting it. In one case he left a forceps projecting through the abdominal wound; the patient lingered on for two weeks and then died suddenly. At the *post-mortem* a gangrenous condition was found extending down from the abdominal wound to the situation of the cervix; it involved the bowel in several places. With regard to the early removal of myomata, it was to be borne in mind that two classes of cases were met with, those that needed operation and those that did not. When a fibroid caused no trouble to the patient, it should not be operated on.

Mr. CHRISTOPHER MARTIN (Birmingham) said that, in discussing the question of early operation for myoma, they must bear in mind the risk of malignant changes supervening in these tumours. He had thrice operated on patients for uterine sarcoma, the history showing that they had for some time suffered from myoma. They had been under observation during that time, but without presenting any symptoms calling for operation. As to the choice of operation, he preferred panhysterectomy, which he had first seen performed by the President in 1894; and the results from this procedure had been so good that he did not think that they could be improved upon. He himself had up to the present time done thirty-five panhysterectomies for myoma with one death.



Dr. WALTER (Manchester) thought that in this, as well as in many other operative procedures in which a great variance of opinion existed as to the question of operation, a middle course was the safest to adopt, and in the absence of symptoms an operation might be postponed unless the tumour were increasing in size. The social position of the patient had to be taken into account; if she were a poor woman with a family dependent on her work, an operation ought not to be performed if it could be avoided. He believed that cases sometimes died from various chronic diseases which were not always recognised as the direct result of the pressure of the fibroid; and that a larger number of deaths occurred after the menopause, either directly or indirectly from the fibroma, than many suspected. He hoped such cases of neglect would not long continue, seeing that the mortality following hysterectomy among skilled operators was as low as 3 to 7 per cent.

Dr. T. M. DOLAN (Halifax) said that the difficulty encountered by the general practitioners was that their patients came to London, where they found two widely diverging schools of thought; according to one school no operation at all should be done in any case of fibroid; according to the other school, nearly every case required operation. While this difference existed among the leaders of the profession, how could they expect the general practitioner to take a high position in the matter? To his mind one point was quite clear; if an artery were bleeding anywhere, the rule was to tie it, or at least arrest the hæmorrhage; and a similar rule should obtain in dealing with fibroids. They heard one eminent man say, "Wait for the change of life"; by the time this came about the patient was probably moribund, and all that was left for the general practitioner to do was to sign the death certificate.

Dr. J. INGLIS PARSONS remarked that the difficulty of the question was this: they would like to operate early on a fibroid that was going to become dangerous; but how were they to determine in the early stages which these

cases were? The experience of years had not yet told them. Then a distinction had to be drawn between hospital and private patients. Dr. Walter had given them one point of view about this; but, for his own part, he rather took the opposite position, namely, that a patient who had to earn her living was disabled from doing so if she had a fibroid; and so he would advise an operation in her case, whereas he would not advise it in the case of a private patient who could afford to be an invalid. He did not regard the possibility of malignant changes in a fibroid as a cogent reason for operating, because such a change was a rare occurrence. He had seen only one case among his hospital patients, and one in the charge of one of his colleagues. The position for them to adopt should be a middle one, between the man who would not touch any case of myoma, and the man who would operate on every one.

Dr. WALTER explained that his remarks referred to a working woman with a fibroid in an early stage, which did not interfere with her work.

The PRESIDENT believed that the mortality of operations for myoma depended not only on the dexterity of the surgeon, but also on his views of the question. One who believed that all cases should be operated on would probably have a mortality of 8 per cent.; one who held the views of Dr. Champneys would probably reach 18 to 20 per cent.; whilst a man who held an intermediate position like Dr. Walter would probably have a mortality somewhere between the two. As to the choice of operation, his own preference was for panhysterectomy; and he congratulated Mr. Christopher Martin on his brilliant results with this operation. It was found that the nearer they got to panhysterectomy in doing a supravaginal hysterectomy the better. The mortality had fallen in proportion as more and more of the cervix had been removed. The objection that panhysterectomy was a tedious operation was answered by the rapidity of Doyen's

operation. He had lately adopted Doyen's procedure with satisfaction.

Mr. STANMORE BISHOP, in reply, said that he was glad to have such a complete answer to the question he had proposed. The cases that needed no operation could be set aside, and, with regard to the other cases, it was evident that the position of the Society was quite against what had been lately expressed by some "leaders" of the profession. He wished to protest against the view that a fibroid tumour should necessarily be left till the menopause. He had lately gone the round of the Museums in London; and the history of nearly every specimen was that the patient had been allowed to linger on till she was *in extremis*, then brought to the hospital, perhaps in a condition of sepsis, or quite exhausted, so that she was either too bad to be operated upon or died at once after operation. It was not only a question of the great dangers incurred when no operation was done, but also of the greater risk attendant on the operation when it was at last performed.

CYST OF THE RIGHT MESO-SALPINX—THE TUMOUR LYING UPWARDS AND TO THE LEFT SIDE, WHILE THE OVARY WAS IN THE NORMAL POSITION, THE DISTENDED FALLOPIAN TUBE LYING FULL ACROSS THE POUCH OF DOUGLAS—COLPOTOMY AND CURETTAGE—RECOVERY. By Dr. MACNAUGHTON-JONES.

The patient from whom these adnexa were removed was 21 years of age. She had been suffering pain from February, 1899. The catamenia were regular, but there was dysmenorrhœa. She met with an accident in the beginning of November, 1899, falling from a height of six feet on to her back. Hæmaturia with pain on micturition followed the accident, and continued for some time. After the catamenial period in November she suffered from an attack which was regarded as one of peritonitis, but the pain passed off; she was married on December 2, ten days

after the completion of the period. Three weeks subsequently pain again set in and continued on and off with more or less severity until I saw her on February 3. She was then suffering considerably. I found the right kidney somewhat enlarged and sensitive, and a pain in the course of the right ureter. There was a muco-purulent discharge from the vagina; the uterus was of normal size and somewhat fixed. A large, fluctuating swelling occupied the pouch of Douglas. The renal signs and symptoms, the presence of the discharge, and the swelling in the pouch of Douglas, made me somewhat diffident as to a positive diagnosis. I hesitated between a pyo-salpinx or a possible early ectopic gestation with renal complications. On operating by posterior colpotomy the day after I saw her, I found the tumour lying mainly to the left side of the pouch of Douglas. The Fallopian tube lay right across, with the right ovary enlarged and cystic. The cyst, which was then about the size of an orange, was tapped of its clear fluid, and, with the ovary, was removed. Nothing abnormal was found at the left side. The patient has since had the uterus curetted, and has made a capital recovery. Mr. Targett, who examined the tumour, reports it to be a unilocular cyst in the meso-salpinx, having the relations of a parovarian cyst. Its wall is rugose and unevenly thickened, consisting of dense fibrous tissue lined with very short, or, in places, flattened, epithelium. It is difficult to account for the relative position of the ovary and the cyst.

Dr. Macnaughton-Jones also showed a solid tumour of the ovary which filled the entire pelvis like a cast, the upper portion being cystomatous. The uterus had been pushed completely upwards, and out of the pelvis. The case had been diagnosed as one of uterine fibroma. This was natural, seeing that only the point of the cervix could be detected, and that it appeared to be one with the tumour. An attack of peritonitis led to the discovery of the tumour in December, 1899, since when it had grown rapidly. After Mr. Targett had examined the tumour he would report as



to its nature. He was indebted to Dr. Allen, of Stanmore, for the case, and also for the following : " Large Fibroma of the Uterus removed from a Patient on whom several operations had been performed for Sarcoma of the Mammary Gland." The patient from whom the tumour was removed was 42 years of age, and married. After a miscarriage nine years ago she suffered from pyo-nephritis, and as far back as that an enlarged uterus was detected. The interesting feature of the case was that within six years she had been operated upon eleven times for sarcoma of the mammary gland. The left breast had been amputated, the glands in the axilla and neck had been removed, as also several small growths about the left side of the thorax. For the last two years the patient had found the greatest difficulty in passing urine and in defæcation. He expected that possibly the tumour was sarcomatous. Microscopic examination by Mr. Targett proved it to be fibroma. Both patients made uninterrupted recoveries.

A CASE OF ACUTE INFLAMMATION OF A SUB-PERITONEAL FIBROID IN A PATIENT FOUR MONTHS PREGNANT.  
By W. WALTER, M.D., Physician to St. Mary's Hospital, Manchester.

The patient, aged 30, and married seven months, was admitted into St. Mary's Hospital, Manchester, on January 9, 1900 ; she was about four months pregnant, and had always enjoyed excellent health. Her periods had never been excessive, but were at times painful. Five days previously she had been seized with pain in the abdomen, on the left side, which gradually increased in severity, and morphia was administered hypodermically.

On admission a hard tumour was felt on the left side of the fundus uteri, and the lower half of the abdomen was tender on pressure. An exploratory incision was made on January 11, and some blood-stained serum escaped from

the abdomen. A subperitoneal fibroid was found attached to the left and front part of the fundus. It was the size of an orange, and was undergoing a process of self-enucleation, the peritoneal covering had been ruptured, and the portion still embedded in the muscular wall of the uterus was attached by fibres undergoing necrotic change, and was easily separated by the finger. The bed of the tumour was sutured with fine silk; from one of the suture holes some free hæmorrhage occurred, but was controlled with a second suture.

The patient made a rapid recovery, and so far no miscarriage has taken place.

Mr. KEITH showed a fibrous tumour undergoing cystic degeneration which weighed 36 lbs. The growth had been removed from an elderly lady of 60 years of age. The history was that, ten years before, the presence of a fibroid tumour of the uterus had been diagnosed. It increased in size very slowly until eighteen months ago. About that time the growth began to increase rapidly, and when she was first seen, six weeks before operation, removal of the growth was advised. The operation was a comparatively simple one, the stitching of the wound taking up most of the forty-five minutes, as about forty deep stitches were required to close the wound completely.

## BRITISH GYNÆCOLOGICAL SOCIETY.

THURSDAY, APRIL 19, 1900.

DR. W. J. SMYLY, PRESIDENT, IN THE CHAIR.

## SPECIMENS.

SOME CASES OF HYSTERECTOMY FOR CARCINOMA AND FOR MYOMA. By F. BOWREMAN JESSETT, F.R.C.S., Surgeon to the Cancer Hospital.

CASE I.—*Vaginal Hysterectomy for Carcinoma Uteri.*

MRS. D., aged 56, was sent to me by Dr. Aust Laurence, of Clifton, and Dr. Broughton, of Usk, on February 3, 1900. She was the mother of five children, the youngest being 13 years of age. Had had good, though tedious labours. Menopause occurred about eighteen months since. On October, 1899, patient noticed slight hæmorrhage; she had suffered from discharge from that time until the time she consulted me; the discharge was offensive and often blood-stained. She suffers no pain nor any bladder or rectal irritation. She has lost flesh slightly, but is now a tall, fine-looking woman.

On abdominal examination nothing is found, no tenderness on either iliac region, and no enlargement of any of the organs.

*Per Vaginam.*—A quantity of foul-smelling discharge is seen escaping from the vagina; on digital examination a large cauliflower growth is felt filling the vagina, the finger can be passed readily around it. The vaginal walls are free as well as both fornices. The uterus is perfectly mobile, and there does not appear to be any thickening in either broad ligament.

I advised immediate operation, and on February 6, with the assistance of Mr. Ryall and Mr. Murray, Dr. English giving the anæsthetic, I performed vaginal hysterectomy.

The patient made an uninterrupted recovery, and left the home a month after the operation.

CASE II.—*Vaginal Hysterectomy for Carcinoma Uteri.*

Mrs. K., aged 38, sent to me by Dr. Fielden, Burgess Hill, suffering from vaginal discharge, on February 24, 1900. Has been married for two years; no family. Has always been regular until lately, when she has at times had some slight metrorrhagia; has suffered from leucorrhœa for some time, and of late the discharge has become yellowish, thick, and occasionally blood-stained. Has slight pain in left iliac region, and no irritation of the bladder.

Dr. Fielden advised her to consult me, as he was of opinion that she was suffering from carcinoma of the uterus.

Abdominal examination revealed nothing. The patient was a well-nourished, healthy-looking, young woman.

*Per Vaginem.*—There was a very distinct fungoid growth from the os on the anterior border. The mucous membranes over cervix and fornices were quite healthy. The uterus was freely movable. Examination caused slight bleeding. I agreed completely with Dr. Fielden, and looking upon the case as one of early carcinoma, recommended vaginal hysterectomy. With the assistance of Dr. Fielden and Dr. Scott, Dr. English giving the anæsthetic, I operated. After dividing the mucous membrane round the cervix, and while using only slight traction, the vulsellum forceps tore through the uterine tissues. It was then discovered that the uterus itself was extensively diseased, being so rotten that it was with difficulty the forceps could be got to hold at all, and the disease was found to have extended through the uterine tissue at a point about the junction of the cervix with the body of the uterus into the tissues and the bladder. While separating this, unfortunately the bladder was torn. The uterus was



then removed, and the broad ligaments secured by ligatures.

The patient made an excellent recovery from the operation, but had a vesico-vaginal fistula through which all the urine passed. On April 14, with the assistance of the same gentlemen, I operated with a view of closing the fistula, and adopted the flap splitting operation as originally proposed by Collis of Dublin, and later practised by Tait in this country.

The opening was of some size, readily admitting the tip of the finger. After separating the vaginal mucous membrane from that of the bladder freely all round, I passed five chromic gut sutures through the vesical portion and inverted the vesical mucous membrane into the bladder and tied the sutures. I then passed five or six deep silkworm-gut sutures from the vagina through the whole thickness of the flaps, entering the needle about three-quarters of an inch from the edges. These were held by catch forceps, with which I united the edges of the vaginal mucous membrane by fine silk sutures. These having been accurately adjusted, I finally tied the deep silkworm-gut sutures, washed out the vagina with sol. hyd. perchlor. 1 to 10,000, and dusting in some iodoform, packed the vagina lightly with iodoform gauze. I then tested the bladder by washing it out with warm water, and found all apparently secure.

Unfortunately, on removal of the deep sutures at the end of a fortnight, it was found that union had not taken place.

*CASE III.—Case of Fibroid in Broad Ligament removed  
with Uterus per Vaginam.*

Mrs. M., aged 42, married, sent to me by Mrs. Alden, M.D., of the Mission Hospital, Canning Town, suffering with extreme pain caused by a fibroid situated in the right broad ligament. Has had no family. Slight menorrhagia. Suffered a good deal of pain at periods, as well as excessive pain being nearly always present.

Dr. Margaret Alden recommended that an operation

should be performed. This was, however, negatived at the hospital where the patient had applied for relief. February 12, in consultation with Mrs. Alden, I examined the patient. A slight fulness was only discovered by abdominal examination over the right iliac region; pressure caused a good deal of pain *per vaginam*. The os was found to be healthy. On the right side and slightly posteriorly a hard tumour was discovered fixed to the uterus, which was pushed completely over to the left. The tumour appeared to be somewhat fixed, was very painful on examination, and was situated apparently entirely in the true pelvis.

The patient said she was quite precluded from getting her living owing to the pain.

I quite agreed with Dr. Margaret Alden and advised operation.

The patient was admitted into the Cancer Hospital, and when under ether was placed in the lithotomy position, and I tried in the first place to remove the tumour by opening up Douglas' pouch and the broad ligament, hoping to be able to enucleate the tumour. I found, however, this was not practicable, so I then decided to remove the uterus as well. This was very difficult, owing to the space occupied by the tumour. I, however, divided the broad ligament in segments on the left side, and then drew the uterus out, and then was enabled to enucleate the tumour and ligature the broad ligament.

The patient made an uneventful convalescence, and is now quite well.

#### CASE IV.—*Abdominal Hysterectomy for Sloughing of the Uterus.*

Mrs. G., aged 58, was sent to Dr. Clement Godson by Mr. Baker, of Waterloo Villa, Hants, in the early part of February, suffering from a foul-smelling discharge. From the condition of things which Dr. Godson found he asked

me to see the patient with him with a view of deciding if it was a suitable case for recommending an operation.

On February 24 Dr. Godson and myself examined the patient. By abdominal examination a large tumour was readily felt occupying the lower part of the abdomen, movable, no pain or discomfort. It was composed of two large bosses, which were situated in either corner of a much enlarged uterus.

*Per Vaginam.*—The os was felt to be open and smooth, and, from all appearances, healthy. Bimanually the tumour was evidently incorporated with the uterus, the whole of which was freely movable. By examination with speculum a dark-coloured stinking discharge was seen pouring from the os. The sound was introduced, but could not be passed for more than three inches.

Patient said she had been quite well until June, when she first noticed a discharge; this gradually increased and became very offensive. She has had no family. The patient has a sallow, unhealthy appearance, a very quick small pulse, and a persistent temperature of from  $101^{\circ}$  to  $102^{\circ}$ . The diagnosis arrived at was a sloughing fibroid of the uterus, and an early operation was recommended.

On February 27, with the valuable assistance of Dr. Clement Godson and Mr. Leaf, Mr. Brown giving the anæsthetic, I operated, performing subperitoneal hysterectomy. There was no difficulty in the operation, which the patient bore well. She was troubled, however, afterwards, with persistent vomiting, which lasted several days. The temperature the day after operation dropped to  $99^{\circ}$ , but the pulse remained very rapid, viz., 132 per minute. There was a good deal of distension. Ordered grs. v. calomel, and large turpentine enema, and to be fed entirely per rectum with beef-tea and brandy, and zymised suppositories.

*March 1.*—Vomiting continued. Bowels not relieved. The calomel and enema were repeated with but little or no effect.

*March 2.*—A dose of castor-oil was given, but still no action, the distension being very great. The temperature, however, remaining normal, but pulse very quick, and tongue furred.

*March 3.*—Flatus passed during the night, and bowels slightly relieved after enema, vomiting not so persistent. Distension still great.

Ordered  $\text{m.j.}$  doses of *nux vomica*, and  $\text{3j.}$  doses of Dinneford's magnesia every four hours.

*March 4.*—Still no action of bowels, more than slight discolouration of the enema.

*March 5.*—Bowels freely opened ; patient from this point rapidly improved.

*March 20.*—A considerable quantity of pus was seen escaping from the os, and on examination a large slough was withdrawn and one of the sutures which were used for suturing the cervix uteri. The discharge still continued, and four days later I removed another long slough and another suture. From this point the patient convalesced well, and returned home a month after the operation.

Dr. J. MACPHERSON LAWRIE (Weymouth), referring to Mr. Jessett's question as to the best time at which to operate when the bladder was accidentally injured during hysterectomy, said that he had himself cut into the bladder in several difficult cases. He had usually repaired the rent at the time, but occasionally later. He had always found that they healed up very quickly. His plan was to denude the edges first. In one case he had got assistance from dilating the urethra and working with one finger in the bladder.

Dr. WILLIAM WALTER (Manchester) said that the question of the best time at which to repair bladder injuries was a very important one. In the few cases that he had been unfortunate enough to meet with, he had always repaired the rent at the time ; and as long as the bladder was sufficiently separated from the uterus so as to get space for working, there was no difficulty. He had found no



necessity for paring the edges of the tear. With regard to the use of the catheter in such cases, his practice was to introduce a self-retaining catheter; this was removed and washed each day, and the bladder was washed out three to four times a day with boracic lotion.

Dr. J. H. DAUBER related a case of carcinoma of the cervix, on which he had operated two years ago. The growth filled the pelvis, and at the first operation he was only able to remove the vaginal part of it. At the second operation he tore the bladder, and postponed the removal of the uterus in consequence. He had no difficulty in suturing the rent at the time, and he left in a catheter for two weeks. At the end of this time he removed the uterus. The bladder was much thinned and dilated. At the time of the accident about two pints of urine came away, although the nurse in charge had withdrawn 24 ozs. of urine immediately before the operation. The patient remained well till lately, and he was now afraid that she had an inoperable recurrence.

Dr. HEYWOOD SMITH thought it was better to simply pass a catheter three to four times a day rather than put in a self-retaining catheter, removing it twice daily. He thought that the latter plan involved more risk of cystitis.

The PRESIDENT said there seemed to be a general agreement that it was better to operate on a bladder-injury at the time of the accident. But if this were not done it was to be remembered that most cases of this accident healed spontaneously.

Mr. BOWREMAN JESSETT, in reply, said that he was very glad to hear the results of these operations in the practice of the Fellows of the Society. He agreed with the use of the self-retaining catheter after the operation; but he did not see any necessity for separately washing the catheter and washing out the bladder several times a day; it was usually sufficient to wash out the bladder through the catheter.

## DEGENERATING FIBRO-MYOMA.

Dr. MACNAUGHTON-JONES showed a large uterine fibro-myoma removed from a patient aged 42. He had seen the case five years previously, and then advised palliative treatment, as there were no urgent symptoms, and the tumour was principally intra-pelvic. On seeing the patient again recently the tumour reached to the umbilicus and its pelvic portion had enlarged. The patient was in perfect health, but seeing the increase of size of the tumour, the prospect of easier delivery of it, as also anticipating degenerative changes in it, he advised removal, which was accomplished by supravaginal hysterectomy, and the patient made a perfect recovery. On opening the tumour, the abdominal portion was found to contain a large degenerating mass in its centre, surrounded by a calcareous zone, and to be attached loosely to the pelvic portion, which was an enlargement of the uterus proper, the cavity being greatly distended, and filled with mucoid fluid; the Fallopian tubes were also much enlarged, and surrounded by the fibroid growth (fig. 1). The case was one typically illustrating the advantage of operation, even though a patient were in apparently perfect health, and when increase in growth was the principal indication for interference.

The PRESIDENT showed three specimens of uterine myoma removed by pan-hysterectomy, two of them being removed by the abdominal route and one through the vagina.

In the discussion on the specimens of myoma shown by Mr. Jessett, Dr. Macnaughton-Jones, and the President—

Dr. F. EDGE (Wolverhampton) remarked that two of the operators had adopted the method of supravaginal hysterectomy, while the President had practised the plan of panhysterectomy. In view of the fact that some of these supposed myomata turned out to be in reality sarcoma, he did not think that the leaving of the cervix was justified, especially as no one could tell beforehand whether the



FIG. 1.—Dual fibro-myoma of the uterus, removed by supravaginal hysterectomy. A considerable necrotic area, surrounded by a calcareous zone is seen in the upper tumour, and the canal of the uterus as well as the fallopian orifices greatly enlarged; the lower mass filled the pelvis (see p. 48). Tumour reached to the umbilicus.

H. MACNAUGHTON JONES.







FIG. 2.—Cysto-sarcoma of the ovary. The solid sarcomatous mass filled the pelvis, the upper portion becoming cystic through degeneration and softening of the sarcoma (see p. 49). Tumour reached above the umbilicus.

H. MACNAUGHTON JONES.





FIG. 3.—Cystic ovaries with nodular salpingitis (see p. 49).



FIG. 4.—Cyst of mesosalpinx simulating an ectopic gestation cyst (see p. 49).

H. MACNAUGHTON JONES.





tumour would turn out to be sarcomatous or not. To leave the cervix infringed the surgical rule that whenever possible the whole of an organ affected with malignant disease should be removed.

#### CYSTO-SARCOMA OF THE OVARY.

Dr. MACNAUGHTON-JONES reported that the ovarian tumour which he had exhibited on the last evening had been examined microscopically by Mr. Targett, and that it had proved to be a spindle-celled sarcoma, the upper portion of which had softened and degenerated into a cyst (fig. 2). The tumour was of an unusually large size for sarcoma of the ovary to attain to. The patient made an excellent recovery.

#### NODULAR SALPINGITIS.

Dr. MACNAUGHTON-JONES exhibited the adnexa removed from a multipara, aged 39. Both ovaries were cystic and adherent. The Fallopian tubes presented the typical appearance seen in nodular salpingitis, characterised by considerable thickening of the tubes, with muscular degeneration, obliteration of the lumen, and nodular enlargements in parts (fig. 3). In this case the tube was directly continuous with the muscular structure of the uterus. The ligature cut the tube completely across. Hæmostasis was secured by passing catgut ligatures through the cornu of the uterus at either side. There was not in this case any history of gonorrhœa, and careful examination of the tubes failed to detect tubercle. The patient had done well.

Dr. Macnaughton-Jones also showed a cyst of the mesosalpinx, simulating ectopic gestation (fig. 4).

Dr. MACNAUGHTON-JONES asked whether Dr. Smyly had employed Doyen's *pincès hæmostatiques*?

The PRESIDENT stated that he had done so in one of his three cases.

Dr. MACNAUGHTON-JONES asked the President if he would say what was his opinion of the value of this plan of

hæmostasis. He proceeded to remark that it would be very interesting if every Fellow of the Society who used lever forceps would report his results, for Doyen's more recent operation of hysterectomy consisted essentially in the employment of the forceps. Doyen's operation had been practised in Vienna, in Berlin by the Landaus, and in other places, but not much, as far as he had heard, in England. He thought that British operators still preferred to resort to the ligature.

Dr. MACPHERSON LAWRIE remarked that Doyen's assistant, Dr. Warden, had told him that Doyen always used the ligatures in addition to the hæmostatic forceps.

Dr. WILLIAM DUNCAN said that the specimens shown formed a very interesting series. With regard to Mr. Jessett's specimen of myoma in the broad ligament, it seemed to him, looking cursorily at the specimen, that the myoma might have been removed and the uterus left. He would like to ask Mr. Jessett how he dealt with the cavity that remained after the enucleation of the tumour. He had had several cases in which there had been such a cavity, and had, as a rule, been able to close it up altogether by the use of a silk suture. Up to the present time he had had sixty-eight cases of intraperitoneal hysterectomy, an account of which would appear in the current number of the *Lancet*. Of these cases, four had died; one of the four had so far recovered that she was about to leave the hospital; and while eating her dinner one day she suddenly fell back dead, from embolism. This death was not consequently attributable to the operation; and he might reckon his mortality at three in sixty-eight, or 4·4 per cent. He did not agree with Dr. Edge that they ought always to do panhysterectomy; for in the vast majority of cases they had to do with a true myoma, and not with sarcoma. Personally, he preferred to leave the vagina unopened whenever this was possible. As regards the indications for hysterectomy, there were three classes of cases where interference was urgently required; first,

when there was much hæmorrhage ; secondly, when the patient suffered from pressure symptoms ; and thirdly, when, even in the absence of marked symptoms, the tumour was growing rapidly. He was not personally acquainted with Doyen's operation ; but he was so well satisfied with the results of intraperitoneal hysterectomy that he was but little disposed to make any change. With regard to Dr. Macnaughton-Jones's case, he considered it was typically a justifiable one for operation.

Dr. HERBERT SNOW took exception to Dr. Edge's statement that these myomata were next door to sarcomata. The malignant degeneration of these tumours was quite exceptional, occurring in certainly not more than about 5 per cent. of cases of myoma. It was true that at the time of operation they could not tell whether a growth was sarcomatous, but they could at least form an idea, from clinical features, whether it was malignant. If the cervix only was left, he could not see that there could arise any danger from the return of myomata ; so it did not seem to him that the small risk of malignancy rendered it worth while to incur the increased risk of danger to the ureters involved in panhysterectomy. He would like to ask Dr. Macnaughton-Jones what means Doyen adopted to check hæmorrhage during the operation, and also what were the results of Doyen's operations as regards mortality.

Mr. BOWREMAN JESSETT, in reply to Dr. Duncan, said that the operation for the intraligamentous myoma was done through the vagina ; he first tried to enucleate the myoma, but was unable to do so, so he had to remove the uterus. No cavity remained after the removal of the tumour. He was formerly much in favour of panhysterectomy, in the introduction of which into England he had some share ; but he had now come to the conclusion that supra-vaginal hysterectomy was safer and quicker. He would like to ask Dr. Edge how many cases he had seen of recurrence after supravaginal hysterectomy ? [Dr. Edge : Five.] He thought that the operation indicated depended on the length

of the cervix ; when this was long he preferred supra-vaginal hysterectomy, but if the cervix were short, a pan-hysterectomy might be better. As regards the results of Doyen's operation, he had seen that eminent surgeon operate on four cases in Amsterdam ; but of these, two, if not three, died.

The PRESIDENT, in reply, said that by "Doyen's operation" he did not understand any one method of hæmostasis ; but rather the plan of opening first the posterior fornix, and then drawing up the cervix, which would be found to shell out very easily from its bladder connections. In this process the uterine arteries were separated from the cervix, until they could be secured in the upper portions of the broad ligament, where they became very small, instead of at the base of the broad ligament, where they were large. Moreover, they could then be secured close to the ovarian vessels, so that one ligature would suffice for both. He considered that Dr. William Duncan's results were excellent ; and as he could show a mortality of only three in sixty-eight cases, he should recommend him to adhere to his present method of procedure. For his own part, he had had very good results from panhysterectomy.

Dr. R. P. R. LYLE (Newcastle-on-Tyne) showed some uterine dilators, which he had had made on the plan of Kelly's urethral dilators. They differed from most dilators of this type in the fact that the graduation of the various sizes, according to the English catheter scale, was very gradual. This facilitated the operation in cases where the cervix resisted dilatation.

PREGNANCY COMPLICATED BY UTERINE MYOMATA AND OVARIAN CYST, WITH A NOTE ON WATSON'S METHOD OF SUB-PERITONEAL HYSTERECTOMY. By RALPH WORRALL, M.D., M.Ch., Surgeon to the Department for Women at the Sydney Hospital.

The following case presents features of more than usual interest, making it, I think, worthy of discussion at a meeting of the Gynæcological Society.



E. McG., aged 35, married two and a-half years, no child, no miscarriage.

*Symptoms.*—Noticed lumps in the abdomen shortly after marriage; these have increased in size and there has been considerable abdominal pain on exertion. Ten days ago (August 28) was seized with very severe pain in the lower abdomen, which lasted several hours. Menses regular and profuse up to May 18, since which the flow has been absent.

*Physical signs.*—Thin, pulse weak; an irregular growth occupies abdomen and reaches two inches above umbilicus. It is very hard and nodular in parts, but to left of centre feels cystic. *Per vaginam*, the inlet of pelvis is blocked by the hard fixed base of tumour which can be in no degree pushed up. The cervix lies high up to the left and is flush with the tumour. In the right kidney pouch there is a cyst, size of a large orange, somewhat movable, not tender; the colon is distinctly in front of this cyst, which was consequently taken to be a hydronephrosis, the diagnosis of the other tumour being "pregnancy complicated by myoma blocking pelvis and rendering delivery at term *per vias naturales* impossible."

*Operation on September 7, 1899.*—The cyst in right loin proved to be ovarian, lying behind and outside of colon, thus simulating renal cyst. The tumour consisted of the uterus gravid about the fourth month, and the seat of a multinodular myoma, with extensive subperitoneal development anteriorly and laterally. No shock. Recovery easy. Highest temperature 100·2°. Highest pulse rate 100.

The method of operation adopted in this case was that elaborated by Professor Watson, of Adelaide. I learnt it from him in January, 1899, and since have had a series of eleven consecutive recoveries. Most of the cases were difficult by reason of subserous development; indeed, three were what Lawson Tait called "terrible cases," that is, where the broad ligaments are obliterated, and the growth being chiefly cervical fills the true pelvis, and is in close contact with ureters and blood vessels.

Dealt with by antiquated methods such tumours are indeed "terrible," but by the procedure which I am about to describe they can be removed almost as easily as if they were pear-shaped tumours.

The tumour is delivered if this can be done easily, but no time is wasted in the attempt, nor in trying to separate adhesions at this stage. In all cases one, and in most cases both round ligaments are accessible; these are immediately double clipped and divided about an inch from the uterus; the proximal clips are replaced by ligatures, and the



ligaments pushed down, thus opening up two rhomboid spaces in the mesometrium. The tumour at once becomes more movable. The serosa between these two spaces is incised, and the bladder allowed to go down. The serosa between one divided round ligament and the infundibulo-pelvic fold on the easier side is incised, opening up this broad ligament, and exposing the large vessels lying on the post. blade. These are gathered up in a bunch, double clipped and divided; a silk ligature replaces the clip on the proximal side. The post. blade of the broad ligament is

divided towards the uterus. The uterine vessels are now clipped, cut and tied on the same side. The manœuvres are repeated on the opposite side (one ovary being left in all cases if possible) and the cervix divided, or the cervix is cut across and the vessels on the opposite side secured from below up *à la* Howard Kelly. A gauze drain wrung out of a biniodide solution and powdered with iodoform is passed through the cervix into the vagina, and the cut edges of cervix sutured with kangaroo tendon over the gauze. The peritoneum is then united by a continuous catgut suture from pelvic wall to pelvic wall and the parietal wound closed. In securing the uterine arteries in difficult cases it is essential to pull the uterus up and to the opposite side away from the ureter. To accomplish this, nothing is so good as a sailmaker's hook, which being conical, and thus acting as a plug, can be boldly dug out into the tumour and great traction exerted.

I would strongly urge my brother gynæcologists to read Professor Watson's original papers in the *Australasian Medical Gazette* of September 20, 1899, and in the *Transactions of the Intercolonial Medical Congress*, 1899. His methods for operating on myomata and carcinomata of the uterus are based upon a profound knowledge of the surgical anatomy of the pelvis, and, in my opinion, we have reached in them finality. However enormous are the vessels which course over the tumour "they are all come home to roost," that is, secure the four cardinal points, and they dwindle to insignificance. No vessel is secured *en masse* within its peritoneal envelope, all are exposed first and then tied, and in consequence there is no liability to slipping of ligatures and no mushroom pedicle to contract adhesions to bowel. No pedicle needle is used, but the vessels are clipped first and then tied, and thus there is no liability to wounding veins and the disastrous results that arise therefrom.

The other great point of difference between this method and that of Howard Kelly is that the latter says, "Deliver the tumour and secure the infundibulo-pelvic fold;" while

Professor Watson says, "Do not deliver the tumour unless it can be done easily, but let go your round ligaments as a first step and the subsequent proceedings will be immensely facilitated." If there are adhesions the tumour can be rolled off them after it has been cut away.

THE PARASITIC THEORY OF CANCER AS A BASIS FOR TREATMENT. By J. INGLIS PARSONS, M.D., M.R.C.P., Physician Chelsea Hospital for Women.

THE fact that the mortality from cancer for three years in England and Wales, from 1894 to 1896, amounted to 67,888 (Registrar's returns) is sufficient excuse, if any were needed, for bringing these views before the Society.

It is not possible within the limits of this paper to describe all the admirable and painstaking work of various investigators on the parasitic origin of cancer. I wish only to point out that San Felice has recently been able to find and grow a micro-organism from cancer corresponding to Russell's fuchsin bodies in the older portions of the growth, and also to produce tumours of adeno-carcinoma in the lower animals by direct infection. His work has received some confirmation by Dr. Plimmer in London and by others. The tumours so produced present a strong resemblance to cancer in the human body. San Felice does not, however, agree with previous observers in thinking this parasite is a protozoon, but considers it to belong to a group of fungi known by name as the saccharomycetes. This is a point of the very greatest interest. Perhaps no group of micro-organisms has received so much attention or been so thoroughly investigated in the last forty years as this, on account of their great importance in the formation of alcohol. I decided, therefore, to see how far these independent investigations of the saccharomycetes in fermentation would help to confirm or repudiate San Felice's conclusion that cancer is caused by one of these fungi.

What are the conditions of life necessary for the growth



and propagation of the saccharomycetes? Are they such as to allow them to exist and multiply in the human body?

The answer to the first question is found in the works of Pasteur, Schutzenberger and others.

What temperature is most suitable? Vital manifestations cease below  $49^{\circ}$  Fahr., or above  $140^{\circ}$  Fahr., while the most favourable range is between  $77^{\circ}$  and  $95^{\circ}$  Fahr. We thus see that the normal temperature of the body is only removed by very little from the most favourable temperature required.

*Respiration.* — Pasteur has demonstrated in the most conclusive way that these fungi absorb oxygen in water and give out a corresponding quantity of  $\text{CO}_2$ . This can take place either in the dark or in the light, and it increases as the temperature rises, reaching its maximum at  $95^{\circ}$  Fahr. When fermentation is going on Pasteur found by numerous experiments that free oxygen is formed in the decomposition of sugar. A much more important and interesting experiment showed that when fresh yeast was diffused in arterial blood it absorbed the oxygen and turned the blood blue. Schutzenberger went a step further and passed arterial blood through a system of hollow tubes of gold-beaters' skin immersed in a mixture of yeast diffused in fresh serum at  $95^{\circ}$  F. The oxygen was absorbed by the yeast and the blood lost its red colour. A control experiment done under the same conditions showed no change in colour.

We may conclude from these experiments that the fungi would have no difficulty in obtaining a plentiful supply of oxygen in the human body through the thin walls of the capillaries. I noticed that Dr. Plimmer, in his paper, thought that the parasites lived under anaerobic conditions in the human body. This appears to be very doubtful.

*Food, &c.*—The chief food of the saccharomycetes is sugar, and Pasteur has demonstrated that a part of the sugar during fermentation is fixed in the fungi in the form of cellulose. As, however, these bodies contain proteids, they also require in food something containing nitrogen.

If some tartrate of ammonia is added to a pure solution of sugar and water, growth goes on more quickly. Other bodies answer the same purpose, and what is more interesting to us is that peptones and in a less degree urea and uric acid will also furnish the necessary nitrogen. Various salts, of which potassium phosphate is the most important, are also required. Finally, it has been found that the serum of blood with some sugar added to it forms one of the best mediums for the growth of these fungi, and contains everything necessary for their propagation.

Water or some degree of moisture is necessary for propagation. This power is lost when yeast is dried. If the drying process is done with care, it may recover on being moistened.

Multiplication can occur in two ways. Under favourable conditions with plenty of food, budding takes place, and a complete fungus is given off from the parent cell; but with several varieties, whenever a deprivation of food occurs, particularly of sugar, the budding ceases and a formation of spores takes place in the course of fifteen or sixteen days. Rees was the first to observe this (*Botanische Zeitung*, 1869), and Hansen has more recently developed this question and given an account of the evolution of various spores. His observations tally with those of Rees as to the conditions necessary for sporing, but he also thinks that a few fungi form spores instead of budding even when food is plentiful.

It is worth observing that, in making these experiments to produce spores, the fungi deprived of sugar are very apt to putrefy, although given the advantages of moisture, warmth, and plenty of air. Knowing as we do now that the ill effects of most micro-organisms are produced by the toxins which they secrete, it is most important to know if these saccharomycetes form anything of this kind.

Apparently they do not. The excrementitious products are principally alcohol, CO<sub>2</sub>, glycerine, succinic acid, leucine, tyrosine and butalamine, and a small amount of fat. Many of the products are harmless to the human body, and are, in fact, also produced by its own metabolism.

A little consideration of the foregoing experiments shows in an unmistakable way that the human body can furnish everything necessary for the growth of these fungi.

The temperature of the body is quite near the most favourable limit for growth.

Blood serum supplies everything required in the way of food. The physiologists have shown us that there is always a small quantity of sugar in circulation amounting on the average in healthy persons to '12 per cent.

Oxygen can be taken from the capillaries which ramify everywhere.

A sufficiency of moisture is furnished by the large quantity of water in the body. As we have seen, light appears to be unnecessary; its absence, therefore, in most parts of the body does not interfere with growth.

Further than this, if we accept these fungi as the cause of cancer we can explain many hitherto obscure points in the clinical history of this disease.

The fact of saccharomycetes being entirely different to the various bacteria causing other diseases, and apparently forming no toxin, explains the absence of inflammatory reaction and temperature in cancer, and other differences from the group of diseases caused by bacteria.

We can also understand why the disease is more rapid in the stout florid person than in the thin dyspeptic subject. The former usually has more sugar than normal in the circulation, while the latter has not. This extra amount of food in the shape of sugar for the fungi enables them to multiply more quickly.

Cancer of the liver is more rapid than any other form, and runs its course usually in from three to twelve months. This organ is the great storehouse for the sugar formed by digestion, which is kept in the form of glycogen ready for use in the body. No wonder, then, that the disease is rapid when the parasites find their chief food in abundance around them.

Cancer of the breast and the uterus in thin old women is

very often slow in its growth.' In these cases the local circulation has diminished since the menopause, consequently the necessary foods, &c., for the parasites brought by the blood vessels are very much less than in the case of women before the menopause. The progress of the disease is therefore slower.

Clinically, I suppose we have all noticed the remarkable difference between one patient and another in the period of time which elapses before a recurrence occurs in the glands connected with the original growth. In one patient three months may give decided symptoms of a new tumour, while in another there may be three or four or more years. I have already described how the propagation of these fungi can take place in two ways, (1) by budding when a fully-organised fungus is given off from the parent cell, (2) by the formation of spores which have to undergo development before attaining their full powers.

When a growth recurs rapidly probably the infection has taken place from fungi produced by budding; while apparent immunity for years, followed by local recurrence, could be explained by the presence of spores which had remained quiescent like seeds until the conditions suitable for germination had arrived.

As we know that cancer may attack any part of the external surface of the body, also any part of the internal surface, including the gastro-intestinal, genital, and respiratory tracts, we should expect (if the cause is a micro-organism) that it would be diffused in the air so that it might come in contact with the external surface, or fall on to food or be carried down to the larynx during respiration.

The *saccharomycetes* fulfil these conditions. Pasteur has shown that they float about in the air and are more prevalent from June to September in the temperate regions. They are found in large numbers adhering to the external surface of grapes and fruit as ripening approaches.

The advantage of moisture to these organisms will



serve to explain the greater prevalence of cancer along the course of the rivers and water-sheds.

Taking all these factors into consideration, it seems very probable that cancer is produced by a micro-organism, and that the organism belongs to the group of fungi known as the *saccharomycetes*.

Beyond a further corroboration of San Felice's experiments, it is doubtful whether the bacteriologist can bring any further evidence. Adeno-carcinoma has been produced on animals by inoculation, and as it is not allowable to test this on human beings, it only remains to take up the question as it now stands and bring it into the domain of practical medicine.

Passing on to the question of treatment, we must, in view of the continued yearly mortality of over 20,000 for England and Wales, acknowledge that our present system of attacking the disease from the outside, whether by excision or caustics or electricity, cannot be considered satisfactory.

We no doubt do good, prolong life, and sometimes save it, but in spite of all our efforts there are the 20,000 deaths yearly, an eloquent testimony to our failures.

Personally, I have not the least intention of accepting our present methods as final, but will continue the fight against this disease as long as I live.

The time has now arrived when we should attempt in a systematic manner, and in co-operation, to attack the disease through the medium of the circulation.

We have before us for encouragement the example of the use of mercury in syphilis. Again, in malaria we see the effect of a drug in destroying a micro-organism inimical to the human body.

We may also be encouraged by the magnificent work done to combat diphtheria by an anti-toxin. Although the probability of neutralising cancer in a similar way is not possible, we may find a toxin to destroy it. Coley's work in this direction is full of encouragement in the treatment of sarcoma.

In the experiment already described for the production of spores by the absence of food, I stated that putrefaction or death of the fungi was very likely to take place.

Can we starve them in the human body? We know that in stout persons who pass a little sugar in the urine, a careful diet will at once get rid of it; but, unfortunately, the physiologists also tell us that a purely proteid diet will not stop the production of sugar in the human body. But it undoubtedly reduces it in the urine of diabetics and stout people. We may therefore expect that the quantity of sugar is also reduced even in healthy persons by appropriate diet. At any rate, it is worth trying if there is the least probability of doing good. The proportion of sugar in the blood is given by Schäfer as 0·12 per cent. If we compare this with the quantity found in saccharine solutions prepared for fermentation, the difference is very great, and would account for the slow propagation in the human body with its  $\frac{1}{10}$  per cent. of sugar as compared with the rapid growth during fermentation in fluids containing 5 to 10 per cent. of saccharine matter, or 50 to 100 times more sugar than is found in the circulation.

Schutzenberger described the experiments made by Dumas with various salts on saccharomycetes. I need only mention those which succeeded in arresting fermentation. They are potassium acetate, sodium sulphide, &c.

In connection with the first, it is interesting to remember that Sir Wm. Broadbent many years ago advocated the injection of acetic acid into malignant growths.

Sodium sulphide owes its activity more to the sulphur than to the soda. Therefore, I determined to try the effect of calcium sulphide, as this salt has already been used and spoken well of by Dr. Ringer in the treatment of boils and scrofula, but it has not answered my expectations. In commencing the treatment of a disease for the first time with a new drug, we must remember that success may depend entirely upon the method in which it is given, also on the purity of the drug. For instance, in syphilis and

malaria we have two examples of disease treated by opposite methods. For the former we give repeated small doses over a long period of time, while for the latter, single large doses repeated occasionally for a much shorter time are more efficacious. It has taken us something like a century to arrive at the best method of giving a drug for each of these diseases.

Cancer has some analogy to syphilis in that it makes slow progress at first, and also exhibits long periods of latency after the primary disease has been disposed of. I therefore decided to try calcium sulphide in repeated small doses. It did not stop the growth, probably because it was decomposed in the stomach. On making further inquiry I found that the salicylate of soda would stop fermentation more readily than anything else. I am now giving this a fair trial. We know that this drug is absorbed and appears in the different secretions as salicylic or salicyluric acid; it ought therefore, to kill the parasite if it is a saccharomycete.

The observations of Mr. Bruhat and Dr. Backer open up another avenue by which we may attack the disease. Not knowing that cancer was possibly caused by a yeast, Dr. Backer suggested that a solution of the saccharomycetes should be injected so as to eat up the protozoa which were then thought to be the cause. This suggestion was the outcome of an observation by Dr. Bruhat that the saccharomycetes attacked and devoured the bacillus aceti. Further observations showed that the young cells of yeast also attacked several kinds of bacteria.

In view of our present knowledge these experiments suggest to my mind the exact opposite of what Dr. Backer suggested. Instead of injecting the yeast, I would inject a bacterium, or rather its toxin. The very fact that the yeast attacks several bacteria shows that the latter are hostile to them and do them harm.

We can in this way explain the improvement which has been noticed in cases of cancer accidentally attacked by erysipelas.

Dr. Reynolds Green has recently pointed out the partnership between yeast and some bacteria in the production of fermentation, by which both organisms profit. This association, known by the name of symbiosis, is characterised by the formation of a large quantity of gelatinous material. We may possibly find some day that colloid cancer is formed in this manner.

It shows us that some bacteria are more inimical than others to yeasts, and we have to determine by experiments, if we can, which variety is most harmful to the yeasts and least damaging to the human body.

We have for a long time known that phagocytosis does not occur with cancer. Although there are plenty of leucocytes in the tissues surrounding a growth, they do not for some reason attack the morbid cells, as we see in other diseases. There must be a reason for this, and I have suggested the absence of a toxin from the yeast parasite would afford an adequate explanation.

May there not be some means of bringing phagocytosis about?

In all probability the good effects observed after the injection of methylene blue, chelidonium majus, alcohol and other fluids are due to the inflammatory reaction which follows, and a local aggressive action on the part of the leucocytes.

As I have said before, we shall never reduce the mortality from this disease by any local treatment. We should, therefore, aim at producing *general* phagocytosis so as to destroy every vestige of the disease, in whatever hidden corner it may be lying in wait.

Above all we must not be discouraged by failure, nor even by hostile criticism from members of our own profession.

In respect to this disease our mental vision appears to have been obscured by the knife. In spite of the universal use of excision, and the continued multiplication and elaboration of operations, the mortality continues to increase,



and now amounts to more than 20,000 a year, England and Wales alone. Is it not time for us to give up this one-sided view and consider what can be done in other directions?

Dr. HERBERT SNOW said that on analysing the scientific and practical points in Dr. Inglis Parsons' paper, they appeared to him to be of a very reversionary order. The reason that the surgical treatment of cancer was unsatisfactory was that operations were often incomplete or performed too late. Many attempts had been made to identify and isolate the germ of cancer, but without success, and until this was done such a paper as they had heard struck him as rather premature. The most rabid bacteriologist must admit that between the phenomena of cancer and those of every other disease due to micro-organisms there was a great gulf fixed. It was difficult to him to suppose that any parasite could produce such phenomena as were found in the secondary deposits of cancer; for instance, the exact mimicry of the structure of the mammary gland by secondary growths in the liver, or the reproduction in the lung of the rectal follicles lined by columnar cells. The paper did not seem to him a practical one.

Mr. CHARLES RYALL congratulated Dr. Inglis Parsons on his courage in bringing forward this paper on a very controversial subject. There was not enough known to enable them to assign the germ of cancer to the group of blasto-mycetes. The latter would grow in certain media, but cancer-bodies would not. Mr. Plimmer, after many experiments, had succeeded in getting the cancer-bodies to grow; and on injecting the culture into the peritoneal cavity of animals, he got a new growth; but it was not of the same character as the tumour from which the culture was obtained, for it was an endothelial, not an epithelial growth. Mr. Plimmer, had, however, told him that he had lately succeeded in producing an epithelial growth in the skin. But results were not at present such as to offer any hope of treatment based on the parasitic theory.

Mr. BOWREMAN JESSETT said that in his opinion cancer was a local disease, and as such should be treated from the outside, surgically, and not from the inside by medicines. There was, no doubt, something in the hereditary theory of cancer ; he made some investigations on this point some years ago, and met with some striking instances of cancer occurring in several members of the same family. He felt sure that if cancer could be seen early enough it could be cured ; the most favourable cases were those of patients at or past middle life ; but the results of operations in young subjects were unfavourable. Repeated operations were sometimes necessary ; but in some cases a cure could be hoped for in the end.

Dr. MACNAUGHTON-JONES thought that in their discussions it was pleasing to sometimes get away from the knife. Although at present no definite bacteriological conclusion was arrived at as to the ætiology of cancer, he thought that it was all-important that they should discuss it. So far from being, as Dr. Snow suggested, an unpractical subject, it was the very reverse. He did not take the paper to be an argument against operation in cases where this was practicable, but an attempt to deal with cases which might be inoperable.

Dr. INGLIS PARSONS could not agree with the aspersion on the medical profession made by Dr. Snow when he said that operations for cancer were badly done. On the contrary, he thought that their surgery was good, whatever might be the result of other methods of treatment. Mr. Jessett had laid down the view that cancer was a local disease as if this doctrine were new ; the very essence of his paper was the assumption that cancer was a local disease at first ; for if due to *saccharomycetes*, the condition must be a local one. Dr. Snow had remarked that the phenomena of cancer were different from those of other diseases caused by germs, but then the *saccharomycetes* were different from any other micro-organisms. He did not advocate that the knife should not be used, but he wished very much to stir

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up the more conservative spirits in the profession as well as others, who did nothing at all for the 20,000 cases that died annually of cancer, to induce them to try some new plan rather than sit by with folded hands on the plea that nothing could be done.

A GERMAN REVIEW  
OF  
THE GYNÆCOLOGY AND MIDWIFERY OF THE LAST  
QUARTER OF A CENTURY.

IN the first number of the *Deutsche Medicinische Wochenschrift* of this year, Professor Fritsch, of Bonn, reviews the progress made in gynæcology and obstetrics during the last twenty-five years. The article is written entirely from a German standpoint, but contains much that will be interesting to our readers as recalling the work of many in that country who have aided in the development of these branches of medical science. We give it here in a condensed form.

IN the sixties nearly all the professional chairs were occupied by elderly obstetricians who could hardly be persuaded to handle a scalpel. The amputation of a polypus, the splitting of a cervix or an abdominal paracentesis, was the most that was attempted. The introduction of antiseptics gave an impetus to gynæcological as to all other surgery, and the advantages gained were not merely in operative treatment. Diseases up to that time deemed incurable were treated with most brilliant success, and the operations disclosed conditions and yielded specimens for scientific investigation which previously had only, and that but seldom, been accessible to pathological anatomy. Before amputation of the portio was practised erosions could not be studied, nor were the diseases and tumours of the uterus and ovaries open to investigation until the extirpation of these organs became common. It is much to the credit of the gynæcologists of the sixties that they



found time, in the intervals of their practical and teaching work, to carry out most of the investigations which then increased our knowledge of these subjects.

Few books have had such curious results as the "Uterine Surgery" of Marion Sims; one may now boldly affirm that all his theories and all his methods were erroneous. He was the first to revolt from the old systematic gynæcology and from the barren dogmas of the old school of therapeutics, and every practical gynæcologist will admit the stimulating effect of his book. It was the first flare of a new fire.

He wrongly attributed dysmenorrhœa and sterility to ante flexion, and his view at once attracted great attention, as many gynæcologists had been working at the question of the *Displacements of the womb*. When the theories put forward in such indubitable wise by B. S. Schultze forced their way to acceptance, by their inherent truth and without controversy on his part, Marion Sims' book became a thing of the past. Great scientific truths are often so quickly accepted that their discoverer is forgotten, and later generations hardly know to whom they owe their advantages, but all his contemporaries are aware that Schultze was the first to teach bimanual examination. In my own student days pregnant women were still examined standing up; now combined examination is firmly established, and no physician omits to use both hands. At a time too when all shook their heads at him, and gynæcologists wedded to Sims' ideas were warring against normal ante flexion as if it were a disease, it was Schultze who first pointed out that retroflexion was the most common of all pathological displacements.

The practical result of Schultze's opinions was the advance made in the use of pessaries, and the foundation of correct treatment in the restoration of the womb to its normal position by hand before the introduction of the pessary, an instrument which may preserve but can never restore the normal position. Every gynæcologist wa( at

that time in the habit of inventing pessaries, indeed Schultze gave quite a number of forms, and the catalogues swarmed with innumerable monstrosities. Simplicity of treatment has conquered here also; the Thomas and Hodge pessaries and the still better one of Carl Braun are the only ones now in general use, except that, for prolapse, Meyer's rings still hold their place. A further improvement is that such materials as hold the dirt, copper rings covered with india-rubber tubing, &c., are now replaced by hard rubber and celluloid which may be moulded in hot water but become rigid in cold.

About the same time English reports on *Ovariectomy* stimulated us to imitation. The operation was a rare one in Germany; Bruns (Tübingen), Köberle (Strasburg), Spiegelberg (Breslau), and a few others, occasionally performed one, but the result was nearly always fatal; all who remember know. There is the more reason to acknowledge the courage of those who, in that grievous experimental period (*Lehrzeit*) did not despond, but set themselves to find out the reasons why the German results were so bad. In the spring of 1874 Olshausen visited England and returned with new ideas as to technic, indeed, in one respect he surpassed our English colleagues, being the first to apply the doctrines of modern antiseptics to abdominal operations. Olshausen was happily associated with Volkman, the spirited champion of Lister's precepts in Germany, and as a logical result the term *Frauenklinik* was first introduced by Olshausen, and by degrees the scope of Maternities and Lying-in Hospitals has been enlarged for the treatment of all diseases peculiar to women.

It was not long before the German results could stand comparison with the English, and skilled hands and trained intellects obtained material for the systematic investigation of ovarian diseases and tumours. Waldeyer in his "*Eierstock und Ei*" had already laid the foundation for exact research, and framed theories on the proliferating

tumours of the ovary, which, indeed, are no less valuable in all essential points at the present day.

Olshausen was, at that time, almost the only man in northern Germany who performed ovariectomy, and, until Schroeder came to Berlin in 1876, nearly all operation cases came to him. He was the only man with any experience to speak of and, therefore, best qualified to write a book on the diseases of the ovaries, and this book, though now supplemented by later ones, remains one of the most important in modern gynæcology.

The classification of ovarian tumours is practically most important. Which are malignant and which benign has not been till quite recently, indeed is not yet completely, decided. Extremes are clear, and everyone can recognise ovarian carcinoma and cystoma simplex (Pfannenstiel), but innumerable intermediate forms still offer a wide field for further study. A recent and valuable discovery, traceable to Wilms and Pfannenstiel's knowledge of the embryo, is that of the so-called ovulogenous ovarian tumours, *i.e.*, the discovery that dermoids are really tumours derived from the ovum. Though not yet quite clear,<sup>1</sup> this discovery is interesting from its connection with the old idea of parthenogenesis, which was considered to be obsolete. In practice the questions of ovarian tumours may be considered settled, the principle being to extirpate every one diagnosed as such.

In 1878, while attention was still occupied with ovarian tumours, Freund published a successful case of total extirpation of a carcinomatous uterus. Since he first performed this operation, which will doubtless make his name immortal, in the ill-lighted attic of a workman's dwelling under most unfavourable circumstances, total extirpation of the cancerous uterus has been done many thousand times. It has not fulfilled the excessive hopes that were formed of it, and of the first hundred cases I myself did

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<sup>1</sup> Cf. *infra* Summary, p. 27, BANDLER, On the Origin of Dermoid Cysts.

I would now consider hardly one-half suitable, yet it is now perfectly certain that uterine carcinoma can be permanently cured. Statistics are of little value. Anyone who operates on every case in which he can possibly extract the uterus will be sure to have many recurrences, but by limiting the indications most satisfactory results will soon be obtained.

Hegar and Kaltenbach's "Operative Gynæcology" appeared shortly before the publication of Freund's paper. In the first edition, only half the size of the fourth and last, Hegar declared that total extirpation was impracticable. This book was the first describing the technic of gynæcological operations.

Hegar has shared in the discussions of all current questions in gynæcology. He must be credited with the modern *operative treatment of myomata*, and at a time when many of our countrymen considered a myoma to be an indication against laparotomy, because it was a mistake to undertake the risk of a dangerous operation for an innocent tumour, he ventured on the extirpation of the largest uterine new growths, and with great success; at that time no one operated on small myomata. Quite independently of Battey and Trenholme, he hit upon *castration* (excision of the ovaries) for the artificial induction of the menopause or anticipated climacteric, and, with Simon, he introduced modern plastic surgery into Germany.

Simon's name is closely connected with operations for fistulæ, and to him we owe the specula still used in all gynæcological operations. After his too early death, the development of the *operation for prolapse* was due to Hegar, whose methods we have all used for years. Modifications were gradually discovered adapted to different forms of prolapse, and it is, perhaps, not now too much to say that the high aim of making a woman quite able to work may be reached, though the necessary operations may be most extensive (e.g., extirpation of the uterus and vagina).



In *Plastic Operations on the Perinæum* the constant tendency has been to pay more attention to the natural conditions, and for this Hegar deserves much credit. Lawson Tait's theoretical methods were adopted for a time—foreign methods being more readily accepted in Germany than our own—but all operators now concur that the simplest way of restoring the perinæum is, as Küstner teaches, to divide the cicatrices and restore the original form.

*Myomotomy* was still a vexed question, and intra- and extra-peritoneal treatment of the stump was hotly discussed. Even then Gusserow declared that in the end the complete method, the immediate closure of the abdominal wound, would be adopted, as in ovariectomy.

*Total Extirpation of Myoma* we owe chiefly to Martin who, if not the first to perform it, has the credit of its introduction and technical development.

Carl Schroeder from the first adopted and defended the principle of intraperitoneal treatment of the stump. Honoured and beloved by all his colleagues, he was at the pinnacle of his fame all too soon taken from us. A pupil of G. Veit's, one of the wisest physicians who has ever lived, he learned as a youth to exercise independent judgment, and laid out his plans for a new text-book at a time when all the important information in the existing works on our special branch of science was contained in the notes, the text being quite out of date. Even in the first issue, before he had much personal experience, Schroeder's text-book, like Billroth's "*Allgemeine Chirurgie*," had the advantage of being readable, and in rapidly succeeding editions soon conquered all the German schools. And he was equally successful in his practical work. When he came to Berlin there was no one north of the Maine except Olshausen who performed abdominal gynæcological operations, and a field that now finds work for 100 gynæcologists became his own. Within a few weeks he published 100 ovariotomies with results better than the English ones. There

is hardly one operation in gynæcology that he did not improve and simplify, and he was a most courageous operator; while many still declared myomata to be unassailable he had already operated on 100 cases, and had even then adopted the principle of abandoning the stump. The conviction we acquired from ten years' work he had from the first.

Till Veit explained that every hæmatocele was the result of the rupture or abortion of a tubal pregnancy, and Werth declared that every *extra-uterine pregnancy* should be treated as a malignant tumour and extirpated as soon as diagnosed, not only was the etiology of ectopic gestation obscure, as indeed it remains at present, but no method of treating it was recognised, but now many operators can show series of fifty successful extirpations of pregnant tubes.

The genesis and nature of *adnexal tumours*, of pyosalpinx and sacto-salpinx, has been greatly elucidated by the study of specimens. In the same way we have learned the diagnosis and pathology of tubal tuberculosis and gonorrhœa. It is indeed only during the last twenty-five years that we have recognised that in women the manifestations of gonorrhœa differ essentially from those of the same disease in man—that we have to deal with the consequences of the infection, which Saenger very properly calls the residual gonorrhœa. The pathological researches of Schauta and Rosthorn have given us much information.

Though the immediate success of many operations has been most brilliant, and the direct danger of extirpating purulent tumours is proved to be very slight, the permanent results were unsatisfactory, and operators in their endeavours to improve these effects have been led on to more and more extended interference. Schauta extirpated the whole of the genital organs on principle. Landau adopted the vaginal method of extirpation with great success. Efforts continue to be made to improve this method by the use of compression forceps.

THE TRENDELENBURG POSITION.—The idea of facilitat-

ing operations by elevating the pelvis was not solely due to Trendelenburg; though the introduction of this position is linked with his name, Freund and Kocks had used it. Every one admits that the ease of operating on a patient in this position has immensely improved the prognosis of all abdominal operations.

Retroflexion was treated more than 25 years ago by stitching the lip of the os to the wall of the vagina, but other more practical methods are more recent. Schücking had the courage to pass a needle through the uterus and so to anteflect it, and the further development of his idea led to the VAGINOFIXATION of Mackenrodt, Dührssen and Gottschalk. This operation is still a subject of discussion, though much less esteemed since the publication of cases in which Cæsarean section has been necessary on account of the artificial position of the uterus.

VENTROFIXATION.—Olshausen's operation is accepted mainly because it is the only method possible in certain conditions (adhesions, adnexal disease).

SHORTENING THE ROUND LIGAMENTS, the least dangerous of all, seems to be the operation of the future. The chief credit of rescuing this method from unmerited depreciation and neglect belongs to Werth, after him to Küstner and Asch. Many women, however, will still prefer the help of pessaries to undergoing an operation.

OPERATIONS FOR FISTULÆ have been much modernised, especially by the principle of flap-splitting insisted upon by Mackenrodt and Walcher. The frequency of vaginal operations leads to many an injured ureter, for which formerly the extirpation of the healthy kidney was the sole and dubious resource. The knowledge that the implantation of the ureter into the bladder can be effected without much technical difficulty has been most beneficial. Cystoscopy, without which the accurate diagnosis of disease of the ureters and kidney is impossible, has also been introduced into gynæcology.

Among the noteworthy researches in pathological

anatomy carried out by gynæcologists, I may mention those by Ruge on endometritis, Pfannenstiel, Martin and his school on ovarian tumours, and most important of all, that of Saenger on deciduoma malignum. Saenger not only found a new growth never before described, but his work led to most interesting physiological researches upon the implantation of the ovum, the genesis of the placenta, and to a comprehensive investigation of the theory of new growths. Marchand, Kossmann, Pfannenstiel, Veit, Peters, Breus and many other authors issued important contributions upon the diagnosis of the new tumour and the physiology of pregnancy with which it is so closely connected.

#### MIDWIFERY.

Twenty-five years ago the attention of obstetricians was being directed chiefly to the mechanism of labour.

Schatz's controversy with Lahs is hardly yet decided, and its literature, though voluminous, is not very attractive. In obstetric operations many advances have since been made, and our treatment of abortion, though no one ignores the danger of interference, has become more active. The benefits of antiseptics in CÆSAREAN SECTION have been remarkable. Before it the most favourable statistics showed a mortality of 50 per cent., compared with the 5 per cent. now due to the operation in the hands of Leopold and others, and the indications are so enfranchised that the perforation of a living child is almost considered a crime.

The burning question whether the uterus should be preserved or removed has, thanks to Saenger's energetic championship, been solved by the Porro operation being abandoned, in principle, in favour of the classical Cæsarean section.

SYMPHYSIOTOMY is an example of rapid popularity and rapid downfall. On its resumption ten years ago it was recommended with such enthusiasm that clinicians on all sides were obliged as a matter of duty to give it a trial. Many allowed themselves to judge it too favourably, but,



although at first it won far more praise than blame, the operation is now, after a few years only, abandoned. No definite field, no definite indication, could be set for its application, and this uncertainty was a greater bar to its performance than its technical difficulties, which are by no means insuperable.

Far more important was Walcher's discovery of the advantage of the dependent position of the legs in cases of contracted pelvis. In connection with depressing the head into the inlet of the deformed pelvis, as taught by Peter Müller and Hofmeier, it is an advance which unfortunately has not yet been generally adopted in practice.

ECLAMPSIA.—Nothing has been written by obstetricians during the last twenty-five years to alter materially our views upon eclampsia. The theory of the kidney of pregnancy, essentially due to Leyden, has been the most important work. Attempts to explain the complex syndromata of eclampsia have only created theories that have been soon abandoned, and efforts in therapeutics have only proved that all methods are inefficient. I have little doubt that the belauded narcotics have soothed many a woman into eternal rest who without them would have recovered from her child-ill.

Pelvic measurement is still carried out by Litzmann's method, though Skutsch, developing Küstner's ideas, has constructed an instrument with which one can ascertain, and not merely as heretofore estimate, the exact length of the *conjugata vera*.

To Bandl we owe some new ideas about RUPTURE OF THE UTERUS and upon the old question of the internal mouth of the womb in pregnancy and labour, which in spite of much excellent work, especially that of Bayer, is not yet settled. Although numerous sections of the pregnant uterus have been published by Zweifel, v. Schroeder, Waldeyer, Leopold, this "Shipka pass," as Peter Müller called it, is not yet clearly understood.

OSTEOMALACIA.—A great advance was made when

Fehling discovered that this disease could be cured by castration, and when Latzko exhibited at Vienna cases that he had treated successfully with phosphorised oil.

PUERPERAL FEVER.—Winckel's book was for decades the only modern work that attempted to discuss the diseases of childbed systematically. From it succeeding generations had got their knowledge, and in principle the question was solved. Puerperal fever was divested of specific attributes, and recognised as an accidental traumatic disease. The logical outcome was local treatment, including, as treatment always should, prophylactic, rational, and symptomatic measures; these were discussed and severally improved. In the game of precautionary rules and anti-parasitic prophylaxis every one overtrumped the other. The theory of puerperal diseases, in fact, went through all phases of modern treatment of wounds. But a calmer view was soon taken about these excessive measures. It was seen especially that overmuch fuss in prophylactic treatment did more harm than good. The changing ideas of exact bacteriologists are often harmful to us practitioners. They are under no obligation to remember that we have to carry out their theories in practice. Though we were first taught that air was harmless and afterwards that it swarmed with dangerous germs, all their theories had to be reflected in our practical measures. The theory of disinfection, even though not yet complete, certainly led to most excellent practical results in the lying-in wards. In 1875 equal care was given to subject and object, indeed the object—the woman in childbed—was taken special care of; to-day she is almost ignored. She was shaved, soaped, scrubbed, sluiced and syringed, while it was taken for granted that the physician's hands could be completely disinfected with dilute carbolic acid. Now we are fighting about how we are to clean our hands—a task many consider impossible—and little trouble is taken about the external genitals of the woman, which indeed are not so accessible to sterilising drugs as the hands of the obstetrician.

One view has fought its way to general acceptance: we all believe that absolute sterility is neither possible nor necessary, and that good results are not to be had by chemical or mechanical means, but depend on a number of different conditions. For a long time it seemed as if antiseptics guaranteed success and technical skill was a matter of no moment. This mistaken idea was gradually abandoned, and operative skill is now properly esteemed.

Of those authors who, by pointing clearly to the good of our endeavours, contributed to our advance, Bumm combined in the happiest way practical experience with theoretical knowledge. Ahlfeld deserves no less credit, for though he stands somewhat apart in his theories about infection, he has discovered much that is important in the teaching of practical disinfection and believes chiefly in alcohol. He has also regenerated the treatment of the after-birth. Though we cannot agree with him altogether in his attack on Credé, he has induced us on consideration to adopt the more expectative treatment which he recommends and which is certainly the proper method.

Brennecker's endeavours to elevate the mental and social position of midwives, and to improve the hygiene of child-bed by the foundation of lying-in Asylums, and Winckel's efforts to make education more profitable, should be mentioned. Students have to thank Winckel for the institution of intern appointments. In nearly all the clinics there are now a number of interns who share in all the work and see all the practice. The introduction of courses of operative gynæcology upon the phantom is also due to him.

The enormous increase of literature is a pleasing sign of the widened interest in gynæcology and obstetrics. It is unfortunate that so few municipal hospitals have special departments for gynæcology. A surgeon may no doubt perform gynæcological operations, but to undertake gynæcological treatment one should have been a practical obstetrician and have learned to understand all the peculiarities of the female character. Every hospital of more than

100 beds should have a gynæcological department. Conservative treatment as well as operative should be encouraged, and we should not see so many poor women who under promise of permanent cure have submitted to some serious operation and, nevertheless, suffer just the same after as before it.



*PRÉCIS OF PROCEEDINGS RELATING TO THE PROPOSED MEETING OF THE INTERNATIONAL CONGRESS OF GYNÆCOLOGY AND OBSTETRICS IN LONDON IN 1902.*

*June 22, 1896.*—At a meeting of Council of the British Gynæcological Society, Dr. Clement Godson in the Chair, it was proposed by Dr. Bantock, seconded by Mr. Jessett, "That the delegates to the International Congress of Gynæcology at Geneva be empowered to invite the Congress, in the name of the Society, to meet in London in 1899." Carried.

*July 7, 1899.*—At a meeting of Council of the British Gynæcological Society, the Secretary, Dr. Giles, read a letter received by Dr. Bantock from Dr. Jacobs of Brussels, asking if the Society were prepared to re-issue the invitation to the International Congress of Gynæcology to meet in London in 1902.

It was unanimously resolved on the motion of Dr. Clement Godson, seconded by Dr. J. J. Macan, "That the International Congress of Gynæcology be asked by the British Gynæcological Society to meet in London in 1902." The Secretaries were instructed to forward a copy of the motion to Dr. Jacobs.

*August 8, 1899.*—At the opening meeting of the Congress at Amsterdam, the above invitation was personally conveyed by Dr. Robert Barnes, Honorary President of the Society. This was seconded by Mr. Jessett.

In September, 1899, Dr. Engelmann, President of the American Gynæcological Society, who was passing through London, had an unofficial interview with the President of the British Gynæcological Society. Dr. Engelmann urged the importance of the next Congress being held in London, and of harmonious and concerted action on the part of the two London Societies; and added that Professor A. R. Simpson would be a President most acceptable to the Americans.

*October 5, 1899.*—At a meeting of Council of the British Gynæcological Society, it was unanimously resolved, "That the Council of the British Gynæcological Society is desirous of co-operating with the Obstetrical Society of London in receiving the Gynæcological Congress in London in 1902; and authorises the executive to take the necessary steps."

In accordance with this resolution, the President, Dr. Macnaughton-Jones, interviewed the President of the Obstetrical Society of London, to ask him to lay before the Council of the Obstetrical Society a letter on the subject. The letter sent was as follows :—

“ October 17, 1899.

“ DEAR MR. PRESIDENT,—The Council of the British Gynæcological Society is desirous of co-operating with the Obstetrical Society in inviting and entertaining the next International Congress in London, in 1902. With this object I have been authorised to communicate with you and to ask you to bring the matter before the Council of the Obstetrical Society. The Council of the Gynæcological Society trusts that the Council of the Obstetrical Society will see the importance of having an International meeting in London. The American gynæcologists are most anxious that the Congress should be held in London. You are doubtless aware that at the Geneva Congress an understanding was arrived at that the 1902 Congress should be held in London. There is no time to lose, as other cities are mentioned and invitations have been given. It is probable that should the Congress not assemble in London it will meet in Barcelona. I hope, therefore, that you will convene a meeting of your Council at an early date to discuss the question.

“ I remain, yours sincerely,

“ H. MACNAUGHTON-JONES,

“ *Pres. Brit. Gyn. Society.*”

*November 2, 1899.*—At a meeting of Council of the British Gynæcological Society, a letter was read from the President of the Obstetrical Society as follows :—

“ DEAR MR. PRESIDENT,—The President and Council of the Obstetrical Society beg to acknowledge the communication of October 17 from the British Gynæcological Society. They have fully considered the proposal contained in that communication, and think it inadvisable that the two Societies should issue a joint invitation to the International Congress of Obstetrics and Gynæcology.

Yours very faithfully,

“ ALBAN DORAN.”

*January 17, 1900.*—Dr. Macnaughton-Jones received a letter from Dr. Mendes de Leon as follows :—“ Before taking a decision as regards the town where the Congress 1902 will assemble, I must inform you that I have been advised by Dr. Jacobs that all the members of the International Committee have voted for London, except the Americans, who prefer Barcelona unanimously. In the event of London being decided upon, would it be possible to have officially the certainty that Dr. Simpson will preside? If so, I should say this would go a

great way to smoothing difficulties with regard to our American colleagues."

*January 25, 1900.*—At a Meeting of Council of the British Gynæcological Society, Dr. Macnaughton-Jones mentioned that Professor Alexander Russell Simpson, of Edinburgh, in reply to an inquiry, had expressed his willingness to serve, if nominated for the Presidency of the International Congress; and the Secretary was directed to write to Dr. Mendes de Leon of Amsterdam to that effect, and to add that the Council of the Society were awaiting the answer to their invitation, conveyed last summer, for the Congress to meet in London in 1902. This letter was sent on *January 30, 1900.*

*February 21, 1900.*—At a Council Meeting of the British Gynæcological Society, a letter from Dr. Jacobs of Brussels, was read, as follows:—

[Translation.]

*"February 7, 1900.*

"DEAR SIR,—I have the honour to inform you that the great majority of the Founders and Permanent Committee of the International Congress has decided that the next Session should be held in London in 1902. I beg you therefore to communicate this decision to the Council of the British Gynæcological Society, and at the same time to thank the President and Fellows of the Society for their invitation. The Founders of the Congress hope that the Obstetrical Society of London will join with the British Gynæcological Society, in order to make this Fourth Session as brilliant as the preceding ones.

*"JACOBS."*

It was unanimously resolved: (1) That the Secretary be directed to write to Professor A. R. Simpson, of Edinburgh, inviting him to be President of the Congress in 1902; (2) that the Organisation Committee be constituted from among the Fellows of the Society; (3) that the Reception Committee of the Congress shall consist of the Organisation Committee and such other British gynæcologists and obstetricians as may be willing to serve; (4) that a provisional Executive Committee be appointed.

In reply to a letter from the Secretary, conveying the invitation of the Council, and dated *February 21*, the following reply was received from Professor A. R. Simpson:—

*"February 22, 1900.*

"DEAR DR. GILES,—I thank the Council of the British Gynæcological Society for the honour they confer on me in inviting me to be the President of the 1902 International Gynæcological Congress, and have much pleasure in accepting their kind invitation. With best regards,

"I am, yours very faithfully,

"A. R. SIMPSON."



*February 26, 1900.*—A letter, dated February 19, from Dr. Engelmann was received by Dr. Macnaughton-Jones, saying: "May I ask you again semi-officially as to the present state of your Societies in relation to the International Congress. As a member of the International Committee, I understand that an invitation has again been extended on the part of the British Gynæcological Society. I can but repeat what I said to you in London, that I deem it most desirable that the coming meeting be held in an English-speaking country. London would be to the best interest of all interested; but I believe that I voice the sentiments of those whom I represent when I say that the feeling is general that the invitation could be accepted only, and the Congress be a success only, if the two great Societies of Great Britain are united in their desire to see the Congress in their midst, and I sincerely trust that some understanding has been arrived at. May I ask you unofficially if such is the case, and what is the present status?"

To this letter Dr. Macnaughton-Jones replied that before Dr. Engelmann's letter had been received, the Founders had accepted the British Gynæcological Society's invitation; he recounted the steps taken by the British Gynæcological Society to secure the co-operation of the Obstetrical Society and the negative results of the negotiations, adding that no effort would be spared to still secure the co-operation of individual members of that Society.

*March 12, 1900.* — Dr. Engelmann replied to Dr. Macnaughton-Jones' letter as follows:—"I am glad indeed to know that the question is now definitely settled and your invitation has been accepted. You know how earnestly we desired London as the place of meeting for 1902, withholding our vote only on account of the lack of unanimity between the two Societies. Now that the invitation has been accepted, I extend to you my congratulations, with pledges of heartiest co-operation personally and on behalf of our National Committee, and I will take upon myself the pleasure of seeing that the National Committee, as well as the American Gynæcological Society, officially convey to the President-elect—Alex. Simpson—their congratulations and assurances of co-operation. You have done well to place at the head this man, who is honoured and esteemed in every land. Let me add, too, as your Society holds the field now, you should be generous, throw aside all jealousies, and take every possible step to secure the co-operation of the Obstetrical, who likewise can afford to ignore smaller matters, as the prominent position they occupy has so long been known and accepted. With assurances of hearty co-operation, Very sincerely, Geo. J. Engelmann."

*March 15, 1900.*—At a Council Meeting of the British



Gynæcological Society, it was proposed that in order to facilitate the issuing of circulars, the Council resolves itself into the nucleus of the Committee of Organisation; that Dr. Macnaughton-Jones be appointed Chairman of the Organisation Committee, Dr. J. J. Macan Treasurer, and Dr. Arthur Giles Honorary Secretary. Carried unanimously.

*April 26, 1900.*—At a meeting of the Organisation Committee it was resolved unanimously that Dr. Macnaughton-Jones be authorised to approach Professor A. R. Simpson, with a view to the nomination of a London President of the Obstetrical Section at the 1902 Congress, and that Professor Simpson be requested to communicate this resolution to Dr. W. S. Playfair.

*May 1, 1900.*—A meeting of past and present teachers of obstetrics and gynæcology at the Metropolitan Medical Schools was held, as the result of which the following letter appeared in the medical journals:—

“INTERNATIONAL CONGRESS OF GYNÆCOLOGY AND OBSTETRICS.

“*Grosvenor Street, W., May 5.*

“SIR,—I beg to forward you a copy of a letter to Professor Simpson, of Edinburgh, drafted at a meeting of the past and present teachers of gynæcology and obstetrics in the Metropolitan Medical Schools now practising in London, which was held at my house on Tuesday last.

“You will observe that it is signed by everyone who comes under that description, without, I believe, a single exception.

“I need only add that our objection to the election of a President is in no way personal to the distinguished obstetrician to whom the enclosed letter is addressed. To many of us—certainly to myself individually, since he is one of my oldest and most valued friends—he would have been a *persona gratissima* for the post.

“Our objection is not to the man, but to the manner in which he was elected.\*

“I am, &c.,

“W. S. PLAYFAIR.”

“To Professor A. R. SIMPSON, M.D., *President-elect of the International Congress of Gynæcology and Obstetrics.*

“*33, Grosvenor Street, London, W.*

“*May 1, 1900.*

“DEAR SIR,—We learn from a circular dated ‘37, Queen Anne Street, April, 1900,’ that it has been decided to ‘hold the Fourth International Congress of Gynæcology and Obstetrics in London in 1902’ under your presidency.

“As past and present lecturers and teachers of obstetrics and gynæcology in the London Medical Schools, we wish to explain to you, and especially to such of our foreign colleagues

as might contemplate attending such Congress, that those who have issued this invitation have assumed a representative position to which they are, in our opinion, not entitled, and which we find ourselves unable to recognise.

"We cannot, therefore, take any share in promoting or joining in such Congress, but trust that you will accept our assurance that our decision has been arrived at with regret, and with no intention of discourtesy to yourself or other visitors, either British or foreign.

"We are, dear sir,

"Very faithfully yours,

"(Signed)

J. WATT BLACK	}	Charing Cross Hospital.
AMAND ROUTH		
T. W. EDEN		
A. L. GALABIN	}	Guy's Hospital.
P. HORROCKS		
J. H. TARGETT		
W. S. PLAYFAIR	}	King's College Hospital.
T. C. HAYES		
J. PHILLIPS		
G. E. HERMAN	}	London Hospital.
A. H. N. LEWERS		
W. DUNCAN		
R. BOXALL	}	Middlesex Hospital.
F. H. CHAMPNEYS		
W. S. A. GRIFFITH		
W. R. DAKIN	}	St. Bartholomew's Hospital.
A. F. STABB		
M. HANDFIELD-JONES		
W. J. GOW	}	St. George's Hospital.
C. J. CULLINGWORTH		
W. W. H. TATE		
J. WILLIAMS	}	St. Mary's Hospital.
H. R. SPENCER		
G. F. BLACKER		
J. B. POTTER	}	St. Thomas's Hospital.
W. R. POLLOCK		
MARY SCHARLIEB		
	}	University College Hospital.
	}	Westminster Hospital.
	}	London School of Medicine for Women.

On receipt of the letter from the London teachers, Professor Simpson wrote to the Chairman of the Organisation Committee as follows:—

"May 5, 1900.

"DEAR DR. MACNAUGHTON-JONES,—I have to-day received the enclosed letter signed by all the teachers of obstetrics and gynaecology in all the medical schools of London. It

would not be wise to persevere in inviting the International Gynæcological Congress to meet in your city under conditions which have not won the sympathy of the majority of our obstetrical and gynæcological brethren. There is still time to allow the permanent officials of the Congress to accept the invitation that was also addressed to them at Amsterdam to hold the fourth meeting in Spain. Were this done, London and other British colleagues might yet find a way of inviting foreign visitors to meet under happier auspices. If the present invitation is pressed, I must ask you to withdraw my name from the circulars. I accepted nomination to the office of President under the impression that the Organisation Committee was more widely representative of metropolitan gynæcology and obstetrics than it proves to be; and if the summoning of the Congress is carried out by the British Gynæcological Society, the President of the Society would naturally become President of the Congress. Believe me,

“Yours very faithfully,  
“A. R. SIMPSON.”

May 8, 1900. — A meeting of the Council of the British Gynæcological Society, and also of the Organisation Committee of the Congress was held, at which the above letters to and from Professor Simpson were read. The Hon. Sec. of the Organisation Committee was directed to lay all the facts of the case before Dr. Jacobs, of Brussels. The Hon. Sec. accordingly wrote as follows (translation):—“At the wish of the Committee formed at the instance of the British Gynæcological Society for the organisation of the London Congress in 1902, a special meeting of which was held this week, I write to inform you of the present position of matters. The Organisation Committee met for the purpose of considering the attitude adopted towards the Congress by the teachers at the general hospitals in London, after a meeting which they held for that purpose. The result of that conference was a letter of which I enclose a copy. As a consequence of this letter Professor Simpson decided to withdraw his name as President. On receipt of Professor Simpson's letter, the Organisation Committee passed the following resolution: ‘That the permanent Secretary of the Congress be at once furnished with a full account of the proceedings as they have been read at this meeting; and at the same time assured that the Organisation Committee are anxious to do all they can to make the 1902 Congress a success, and will continue energetically with the work which they have commenced.’ Accordingly I enclose the *précis* as read at the meeting, showing: (1) the circumstances under which the invitation of the British Gynæcological Society to the foundation members was issued and accepted; (2) the circumstances connected with the invitation

to Professor Simpson to act as President; (3) that before the invitation was accepted, the Obstetrical Society of London was asked to co-operate, and that its individual members have since been asked to join the Committee.

"You will see from the resolution quoted what is the attitude of the British Gynæcological Society and of its Organisation Committee towards the Congress; but the Society feels that it is just that in view of the opposition of those members of the Obstetrical Society of London who are past or present teachers at the medical schools, and in view of Professor Simpson's decision, it should place itself at the disposal of the Founders, and that those gentlemen should be offered the opportunity of reconsidering their acceptance of the invitation."

A similar letter was sent to Dr. Engelmann and to Dr. Mendes de Leon.

The following letter was addressed to the same medical journals which published that of the teachers of obstetrics and gynæcology at the Metropolitan Medical Schools and appeared in their next issues:—

"INTERNATIONAL CONGRESS OF GYNÆCOLOGY AND OBSTETRICS.

"SIR,—We are directed by the Council of the British Gynæcological Society and by the Organisation Committee of the International Congress, to request your kind insertion of the following reply to the letter appearing under the above heading in the *British Medical Journal* of May 12.

"In the letter signed by the past and present teachers of gynæcology and obstetrics in the Metropolitan Medical Schools, and in the covering letter of Dr. Playfair, two reasons are assigned for the inability of the signatories to take any share in promoting or joining in this Congress.

(1) "That those who have issued this invitation have assumed a representative position to which they are, in the opinion of the signatories, not entitled, and which they, the signatories, find themselves unable to recognise.

(2) "That the signatories object to the manner in which Professor A. R. Simpson was elected President of the Congress.

(1) "With regard to the first point, the British Gynæcological Society, who issued the invitation, is not concerned to defend itself against the opinion held by the signatories that it 'has assumed a representative position to which it is, in their opinion, not entitled.' If a glance through the list of Fellows of the Society were not sufficient to correct such an opinion, the fact that the Permanent Committee of the International Congress of Gynæcology and Obstetrics, representing the leaders of these branches of medicine on the Continent and in America, requested the Society to repeat the invitation which it issued first in 1896, testifies to the opinion of the Society's representa-



tive character which is at least held abroad. In accordance with this request the invitation was repeated at Amsterdam in 1899, being personally presented by Dr. Robert Barnes, Honorary President of the British Gynæcological Society, and an ex-President of the Obstetrical Society of London.

(2) "As to the manner in which Professor Simpson was elected, he was nominated at a meeting of Council of the British Gynæcological Society, on whom the duty necessarily devolved. Professor Simpson was nominated on the grounds, first, that he was an ex-President of the Society, and one of its most honoured Fellows; secondly, that before the Society's invitation was accepted his name was suggested by Members of the Permanent Committee on the Continent and in America, as that of a man who would be acceptable to all the Members of the Congress.

"In conclusion, we can only express our regret that our *confrères*, the teachers of gynæcology and obstetrics at the Metropolitan Medical Schools, should have found themselves obliged to come to the decision expressed in their letter. We are, &c.,

"(Signed) W. J. SMYLY,  
"President British Gynæcological Society.

"H. MACNAUGHTON-JONES,  
"Chairman Organisation Committee of the  
International Congress of Gynæcology and  
Obstetrics.

"ARTHUR E. GILES,  
"Honorary Secretary of the British Gynæ-  
cological Society and of the Organisation  
Committee of the Congress."

May 15.

The following letters have been received while the above was in the press.

(1) From Dr. Engelmann, President of the American Gynæcological Society.

"208, Beacon Street, Boston.

"May 15, 1900.

"DEAR DR. MACNAUGHTON-JONES,—I can but congratulate you on the step you have taken in reference to the organisation of the Congress. You have been prompt, judicious and just; do not lose sight of the rights, if I may say so, or the just claims of the Obstetrical Society—do too much rather than too little. It will do you no harm but good—it will do far more than words to establish better relations between the two Societies; above all it will result in benefit to the Congress and will secure you the approbation and esteem of your colleagues.

"Suggestions I have made, are due to a deep interest in the

success of this first International Gynæcological Congress under Anglo-Saxon auspices and also to the warm feeling I have for my friends in Great Britain, which is shared by my countrymen, as you will see from the expression they have given to this feeling by the vote passed at the recent meeting of the American Gynæcological Society, instructing me to convey to Professor Simpson, your President, the good wishes of the Fellows, with assurances of interest and co-operation.

"I tell you this now because I am sure that at this early day every expression of interest will be appreciated.

"With best wishes,

"Yours sincerely,

"GEO. J. ENGELMANN."

(2) From Dr. Jacobs, of Brussels, Secretary to the Permanent Committee of the International Congress of Gynæcology and Obstetrics, to Dr. A. E. Giles.

[Translation.]

"May 28, 1900.

"MY DEAR COLLEAGUE,—I have the honour to acknowledge the receipt of the papers sent me by you concerning the proceedings which have taken place in the course of organising the London Congress.

"On the advice of a number of the founders, I think the proper course is to ask you to postpone any decision till after the meeting of the Congress at Paris on August 2.

"I will summon a meeting of the founders at Paris to decide about the next Session. In order that we may have full information I will venture to ask you to attend the meeting. With every assurance, &c., &c.,

"(S.) JACOBS."

AMERICAN GYNÆCOLOGICAL SOCIETY.

PROGRAMME OF THE TWENTY-FIFTH ANNUAL MEETING, WASHINGTON, D.C., May 1, 2, and 3, 1900.

*President*: George J. Engelmann, Boston; *Vice-Presidents*: Edward L. Duer, Philadelphia; Seth C. Gordon, Portland; *Secretary*: J. Riddle Goffe, New York; *Treasurer*: J. Montgomery Baldy, Philadelphia; *Council*: Albert F. A. King, Washington; Joseph Taber Johnson, Washington; James R. Chadwick, Boston; Edward P. Davis, Philadelphia.

Address of Welcome: "The Technic of Operations for Intra-ligamentous Tumours," W. H. Wathen, Louisville, Ky.; "Fæcal Fistulæ," I. S. Stone, Washington; "A Study of the Remote Results of Conservative Operations on the Ovaries and Tubes," W. L. Burrage, Boston; "Internal Secretion of the Ovary," A. W. Johnstone, Cincinnati; "The Technics, Indications, and Ultimate Results of Suturing the Round Ligaments to the Vaginal Wall for Retroversions and Flexions of the Uterus," Hiram N. Vineberg, New York; "A Comparison of Vaginal and Vaginal and Abdominal Operations," G. Richelot, Paris, France; "Demonstrations of Casts Illustrating the Anatomy of Pregnancy and Labour, also Models Used in Gynæcologic Teaching," J. Clarence Webster, Chicago; "Combined Nephrectomy and Ureterectomy," E. E. Montgomery, Philadelphia; "The Anastomosis of the Ureters with the Intestines—An Historical and Experimental Research," Reuben Peterson, Chicago; "A Critical Survey of Ureteral Implantation," J. W. Bovée, Washington; "Migrated Ovarian Tumours," George M. Edebohls, New York; "The Best Method of Extirpating Fibroid Uteri," Howard A. Kelly, Baltimore; "An Appreciation of Kelly's Method of Removing Fibroids of the Uterus," A. Laphorn Smith, Montreal; "Bronchial Disease not Invariably a Contra-indication for Ether Anæsthesia in Abdominal Surgery," Thaddeus A. Reamy, Cincinnati; "The Treatment of Full-Term Ectopic Gestation—Should not the Child Receive more Consideration?" Edwin B. Cragin, New York; *President's Address*; "The Relationship between Dysmenorrhœa and Appendicitis," Archibald McLaren, St. Paul, Min.; "Clinical Data Relating to (a) Urinary Toxæmia; (b) the Operative Treat-

ment of Uterine Displacements; (c) Ectopic Gestation; (d) Certain Complications of Uterine Fibroids," Egbert H. Grandin, New York; "(a) Demonstrating the Utility of a Certain Chart for the Determination of Pelvic Asymmetry from a very Simple Method of External Pelvimetry; (b) the Advantages of employing a Certain Background in the Photography of Pathologic Specimens," Philander A. Harris, Paterson, N. J.; "A Contribution to the Management of Face Presentations, with Report of Two Cases," Malcolm McLean, New York; "The Pernicious Nausea of Pregnancy, with a Report of Cases and Autopsy," E. P. Davis, Philadelphia; "Personal Reminiscences Associated with the Progress of Gynæcology," T. Addis Emmet, New York; "The Status of Gynæcology in 1876 and in 1900," Alexander J. C. Skene, Brooklyn, New York; "Reminiscences of the Foundation and Early Years of the Society," James R. Chadwick, Boston; "The Personal Factor in the Work of the American Gynæcological Society," E. van De Warker, Syracuse, New York; "Some Kaleidoscope Pictures in Rhyme," Thaddeus A. Reamy, Cincinnati; "In Memoriam—Charles Pajot," Samuel Pozzi, Paris.



THE 13th INTERNATIONAL CONGRESS OF MEDICINE,  
PARIS, AUGUST 2—9, 1900.

As an item in the Exposition Universelle Internationale the ensuing Congress in Paris becomes a government affair and under the direction of the Minister of Commerce, Industry, Posts and Telegraphs; the rules, regulations and preliminary agenda are issued from the national printing office.

The following information will interest our Fellows.

CLASS IV.—OBSTETRICS AND GYNÆCOLOGY.

(a) *Section of Obstetrics.*

*President*: M. Pinard. *Vice-Presidents*: MM. Budin and Herrgott (Nancy). *Secretaries*: MM. A. Bar and Champetier de Ribes. *Members*: Charpentier, Crouzat (Toulouse), Demelin, Doléris and Fochier (Lyons), Gaulard (Lille), Grynfeldt (Montpelier), Guéniot, Hervieux and Lefour (Bordeaux), Maygrier, Porak and Queirel (Marseilles), Ribemont-Dessaigues and Varnier.

*Papers*: (1) "Etiology and Nature of Puerperal Infections," by Doléris (Paris), Pestalozza (Florence), Menge and Kroenig (Leipzig). (2) "On the Treatment of the Apparent Death of the New-born Child," by Ribemont-Dessaigues (Paris), F. H. Champneys (London), Fr. Schultze (Jena). (3) "Application of Radiography to Obstetrics."

(b) *Section of Gynæcology.*

*President*: M. Terrier. *Vice-President*: M. Pozzi. *Secretary*: M. Hartmann. *Members*: MM. Bouilly, Henry and Delagenière (Le Mans), Lannelongue (Bordeaux), Laroyenne (Lyons), Monprofit (Angers), Quénu, Richelot, Schwartz and Segond.

*Papers*: (1) "Surgical Treatment of Cancer of the Uterus," by Richelot (Paris), Dimitri de Ott (St. Petersburg), Montgomery Baldy (Philadelphia). (2) "On Cervical Metritides," by Pozzi (Paris), Döderlein (Tübingen).

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INTERNATIONAL CONGRESS OF MEDICAL  
ELECTROLOGY AND RADIOLOGY.

At the request of the French Society of Electrotherapy and Radiology, the International Congress of Medical Electrology and Radiology is also to form part of the International Congress of 1900.

A Commission has been asked to assure its organisation composed of: Messrs. Weiss, Professor at the University of Paris, *President*; Apostoli and Oudin, *Vice-Presidents*; Doumer, Professor at the University of Lille, *General Secretary*; Moutier, *Secretary*; Boisseau du Rocher, *Treasurer*; and of Messrs. Bergonié, Professor at the University of Bordeaux; Bouchacourt, Branly, Professor at the Catholic Institute of Paris; Larat, Radiguet, Villemin, Surgeon of the Hospitals of Paris.

This Congress will take place in Paris, from July 27 to August 1, 1900.

Further information may be obtained from Professor E. Doumer, General Secretary, 57, Rue Nicolas-Leblanc, Lille.

Adhesions are to be sent to Dr. Moutier, 11, Rue de Miromesnil, Paris.

## REVIEWS.

A MANUAL OF GYNÆCOLOGICAL PRACTICE FOR STUDENTS AND PRACTITIONERS. By Dr. A. DÜHRSEN, Professor of Midwifery and Gynæcology in the University of Berlin. Second English Edition, translated and edited from the sixth German Edition by J. W. TAYLOR, F.R.C.S.Eng., &c., &c., and FREDERIC EDGE, M.D. Lond., &c., &c. With 125 illustrations, pp. xlii. and 279, cr. 8vo. Price 6s. London : H. K. Lewis, 1900.

Professor Gusserow, who deprecated the increasing desire to learn everything clinically, encouraged the author to publish the first edition of this work in 1891, as a condensed sketch of the whole field of gynæcology, giving a detailed description of the smaller operations, the technicalities, and especially of the duties of an assistant on ordinary occasions. In Germany the book was so successful that the fourth edition appeared in 1894, considerably enlarged by the addition of the author's vaginal method of operating for retroflexion, his vaginal cœliotomy, his wedge-shaped excision of the anterior cervical lip for metritis, his uretero-vaginal plastic operation, and of Vuillet's operation for stenosis of the internal os, Küstner's operation for inversion, Martin's abdominal extirpation of the uterus for myomata, and Péan's uterine castration. The first English translation was made from the fourth German edition, and Mr. Taylor and Dr. Edge, to bring their book up to the level of the most recent practice and theory of gynæcology, have now revised it with the necessary corrections and additions in accordance with the sixth German

edition published in 1899. The technique of vaginal fixation has been so far modified by Dührssen that he now makes it an intraperitoneal operation. He has latterly used only one fixation suture, which is passed through the vagina and peritoneum near the upper end of the peritoneal opening. The peritoneum is closed by a continuous catgut suture and the vagina in the ordinary way, and a purely seroserous cohesion with the fundus arises which stretches during pregnancy. Dührssen admits that after the earlier form of suture the broad fibroserous union of the fundus led to alteration in the form of the gravid womb, to abnormalities in the pains, and to faulty positions of the child.

The only cases of retroflexion for which he deems his vaginal fixation unsuitable are those met with soon after labour, and without complications which require further treatment. With intraperitoneal vaginal fixation he has had a mortality of 2 per cent. but not a single relapse. Many gynaecologists think it wiser in cases requiring operation before the climacteric to adopt some other method. By vaginal fixation combined with colporrhaphy he has treated prolapse most successfully. The translators recommend double lateral colporrhaphy for complete vaginal prolapse.

Dührssen mentions the undoubted success of Thure Brandt's non-operative method of treating displacements, which was commended to the notice of the British Gynaecological Society in 1889 by its President, Dr. A. V. Macan. The long duration of the necessary daily treatment is a serious disadvantage of this method. Mr. Taylor and Dr. Edge attach a greater importance than Dührssen to castration for myoma. They say it should be the operation chosen except for submucous fibroids easily removable from the vagina, and that hysterectomy should not be adopted unless removal of the appendages is impossible. Unsuccessful castration they consider a ground for supposing that a malignant growth has been mistaken for a fibroid.



The book, for its size, is a remarkably good one; sacrifices have been made for conciseness, and as was natural and perhaps not undesirable, what would otherwise seem an undue proportion of space is devoted to the special methods of its talented author. The anatomical introduction and the notes of the translators materially add to the value of the work. A large number of the illustrations, notably those from Schultze, are more or less diagrammatic, and show pretty well; the clichés of others exhibit signs of wear. There are few, if any, typographical errors; "Kolpocœliotoma" (in the text) is one we hope, otherwise it is a barbarism that it would be hard to defend.

PRACTICAL MANUAL OF DISEASES OF WOMEN AND UTERINE THERAPEUTICS FOR STUDENTS AND PRACTITIONERS. By H. MACNAUGHTON JONES, M.D., M.Ch., &c., &c. Eighth Edition. Revised and enlarged, with 640 illustrations and 28 plates; pp. xxx., 948. Demy 8vo. Price 18s. net. London, 1900: Baillière, Tindall and Cox.

The first edition of this work appeared in 1884, and was avowedly an examination book; a large issue was exhausted in a few months, and three editions required within two years justified the author in his hope that the book would prove a reliable introduction to clinical study and a safe guide to the practitioner. By enlargement, rewriting, rearrangement and improved and more complete illustration, the seventh edition, which appeared in 1897, had become a different book, and not only furnished a complete exposition of the author's opinions and practice, but was an admirable epitome of gynæcology brought up to the date of its issue from the press.

The change now effected in the size of the book to demy octavo has allowed the addition of much valuable and recent information, and is a material improvement from the reader's point of view. This is particularly remarkable with regard

to the plates and illustrations, which by their accuracy and admirable execution confirm and elucidate the text. The number of pages is practically the same as in the seventh edition, but the volume, though still bulky, is proportionately less so.

In the earlier chapters of the work we now note two admirable illustrations of the vascular and lymphatic system of the pelvis. Czempin's operating table is omitted, and more modern ones used by Doyen and others for the Trendelenburg position are given, as well as two excellent cuts, after Kelly, showing the method of bimanual examination. An early chapter is now devoted to the consideration of asepsis and antisepsis in gynæcological surgery, with a full description of all the appliances indispensable for the complete installation of the operating room, for carrying out the necessary precautions as regards patient, operator, assistants and nurses, and for sterilising clothes, instruments, ligatures, dressings, &c., and so preserving them. Dr. Macnaughton Jones defines asepsis as the absence of all septic organisms, antisepsis includes the methods by which asepsis is obtained. Modern surgery proceeds on the assumption that the skin of the patient, of the surgeon and of the assistants is infected till rendered aseptic, and endeavours by antiseptic measures not only to secure the aseptic condition but to maintain it throughout and after an operation. Ten minutes at least should be devoted to the disinfection of the hands, by washing with antiseptic soap in running water, soaking in corrosive sublimate solution (1 : 1000) and afterwards in absolute alcohol, and this after the ordinary clothes are covered. The nurse who prepares the patient must not touch anything to be used during the operation. Sterilised pads of gauze are useful to enable assistants without contamination to remove the lids of jars. The author speaks highly of chinosol and formalin as disinfectants—especially of the Alformant lamp for disinfecting a room for operation. This room, in a private house especially, should be well away from lavatory or housemaid's closet.

The chapters on Minor Gynæcological Operations and those on the Disorders of Menstruation are rearranged, and the author again points out that, in spite of its dangers, the benefit that women in most cases derive from cycling are not to be underrated; he insists on the harm from overwork and otherwise to which girls are too often exposed by the neglect of proper care and intelligent supervision by the principals of boarding schools; upon the danger of the abuse of stimulants and of hypodermic injections of morphia in neurotic cases; and of the necessity in the Weir-Mitchell treatment of personal supervision by the medical man, rather than the uncontrolled discretion of the nurse, to modify the rules to suit the individual patient. Much stress is laid on the value of *hydrastis canadensis* and stypticin in hæmorrhage and that of *strophanthus* in dysmenorrhœa with cardiac incompetence.

The use of the sound has its well-known dangers, on which the author properly insists, but he has never seen any harm accrue from its "judicious" use as a repositor of the displaced womb. He points out, however, the value of the postural method combined with bimanual, abdominal, vaginal and rectal palpation in the separation of adhesions and the restoration of the uterus to its proper position. He recognises that neither anteflexion nor anteversion are in themselves pathological conditions, and that only extreme degrees require treatment, but he does not undervalue the use of a well adjusted pessary even in anteversion; several of the stemmed pessaries figured in previous editions are omitted. The different operative methods of treating backward displacements are given. Many will agree with Bouilly and Noble that ventrofixation should be reserved for cases which are complicated by adnexal affections, and will otherwise prefer Alexander's operation to any other. Various methods of amputating the cervix, including Martin's, Doyen's operation for inveterate prolapse, Kelly's bilateral operation for relaxed vaginal outlet, and his method of treating complete tear of the recto-vaginal septum, and

Küstner's operation and its modifications by Doléris and Furneaux Jordan, add to the interest of the next two chapters.

In inflammations of the uterine tissues, in addition to curettage and chromic acid, the author lays stress on the importance of attention to the general health and the local effects of the hot douche, depletion, vesication of the cervix, and tampons of iodine, ichthyol and hydrastis. He never injects drugs into the uterine cavity.

The vaginal route of relieving pelvic suppurations has not, it is true, been so generally adopted in Great Britain as on the Continent, but it is so by some of our most distinguished men.

The surgical treatment of uterine fibro-myomata, with a chapter on Post-operative Treatment, now occupies upwards of one hundred pages, and includes the description of vaginal panhysterectomy, hysteromyomectomy, supravaginal hysterectomy, Doyen's method of complete extirpation by ligatures, lever-pressure forceps or clamps, and the method adopted by Skene and Jacobs with electro-hæmostasis, morcellement as performed by Landau, Schauta, Pozzi and Doyen, enucleation as done by Martin, Spiegelberg and Alexander; decortication and salpingo-oöphorectomy. The illustrations are particularly good, and Dr. Macnaughton-Jones having had the advantage of seeing most of these distinguished operators at work, has been able to give descriptions far more graphic than would otherwise have been possible. We are glad to be assured that tumours which give rise to only slight symptoms receive no such treatment, and serious disturbances alone indicate operation. In this edition various extraperitoneal methods of treating the pedicle are omitted as obsolete.

In regard to deciduoma malignum, Veit's conclusion that it is a sarcoma modified by pregnancy is being more generally accepted; but should Pick's observations as to innocent metastases be confirmed, this view cannot be regarded as an established explanation of its pathology.



Minor operations for cancer of the uterus have gradually given way to hysterectomy, vaginal or abdominal. Full illustrated descriptions are given of the methods adopted by Kelly, Doyen and Martin. As regards palliative measures, next to zinc chloride, on which Jessett reported favourably quite lately, the author recommends fuming nitric acid, or chromic acid, which he finds relieves pain and checks hæmorrhage and ulceration. Cocaine has failed in his hands, and morphia must be our ultimate resource. Anti-septics are indispensable. A corrosive sublimate vaginal irrigation (1 : 3000), followed by a tampon of chloral and iodoform, is recommended by Sirédy, to be renewed in two days, and afterwards as necessary.

While the influence of heredity is now greatly discredited, it is acknowledged that uterine cancer is more prevalent than formerly; it affects multiparæ chiefly and almost in proportion to the number of conceptions; complete and early extirpation is indicated by the fact that in cervical carcinoma the endometrium is more often affected than was supposed (Abel).

The affections of the tubes are treated from the clinical rather than the pathological point of view. Uterine inflammation, especially perimetritis, is very frequently the cause of tubal disease, and palliative measures merely defer, according to the author, radical interference to more unfavourable conditions. Pyosalpinx he recognises as invariably due to infection of some kind, and it is one of the common consequences of attempts at criminal abortion. Tubal Pregnancy has now a chapter devoted to it; von Tussenbroek's case of ovarian pregnancy<sup>1</sup> is quoted as possibly authentic. The immediate removal of the foetus and of the placenta, when this can safely be managed, is recommended.

From his own experience the author is able to endorse Spencer Wells' statement that recovery, marriage and child-bearing has, in no few instances, followed other treatment

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<sup>1</sup> *V. infra*, "Summary," p. 49.—ED.

after operation in ovarian affections has been advised and declined, and it is, we hope, true that no surgeon would now be justified in removing an ovary in which there were not unmistakable signs of disease, merely because he was obliged to remove the other one. For ovarian tumours the one treatment is ovariectomy; tapping and all other forms of palliative treatment have fallen into deserved disrepute.

An interesting quotation from Kelly analyses 126 ovariectomies in children. Of the 126, 22 were fatal, 50 per cent. of the patients under four years of age dying after operation. Of the tumours, 30 were unilocular, 24 multilocular cystomata; 1 an adeno-cystoma; 43 dermoids; 3 teratomata; 16 sarcomata; 1 myxo-sarcoma; 1 semi-solid tumour; 1 papillary cystoma and 6 carcinomata. Kelly also records 22 cases of adnexal tuberculosis in children, the disease occurring in half the number below the age of six.

The author has met with one oozing papillomatous tumour (p. 751), a raspberry-looking mass such as described by Emmett; the observation might be compared with the herpes vegetans (p. 757).

The various affections of the vagina and urethra, with the operations for fistulæ; the affections of the bladder, ureters and kidney in their relation to gynæcology, with a detailed account of the most recent methods of investigation according to Kelly; such affections of the rectum as are within the general scope of the work and the necessary consideration of massage and electro-therapeutics and the vibration treatment of uterine and adnexal affections recently introduced by Jayle and De la Croix de Lavalette, take up most of the remainder of the work.

In the Appendix is a notable illustration of a case of carcinoma psammosum which the author had the opportunity of seeing in Schauta's Clinic at Vienna.

The book throughout impresses one with the comprehensive grasp the author has been enabled to take of the whole field of gynæcology by his own practical experience

and by his intelligent appreciation of the work done by his colleagues, and as the book is eminently a readable one, the interest being constantly maintained by clinical illustrations, we have no doubt it will meet with at least as wide an appreciation as welcomed the earlier editions.

ANÆSTHETICS : THEIR USES AND ADMINISTRATION. By DUDLEY WILMOT BUXTON, M.D., B.S., Administrator of Anæsthetics and Lecturer in University College Hospital. Pp. xvi., and 320 ; 50 illustrations, cr 8vo. Third Edition. Price 6s. London : H. K. Lewis.

The third edition of this work has been practically re-written, and many additions have been made in the text and in the illustrations, with the result that what has always been an excellent text-book has now been brought thoroughly up to date. All the best apparatus are fully described, as well as the various anæsthetics used, and the various methods of administering them. A notable addition is a full account of the production of prolonged anæsthesia by nitrous oxide, and of the different methods and apparatus employed. Local anæsthesia by injections of cocaine and eucaine is fully and clearly described and illustrated, as is also Bier's method of introspinal injection for producing analgesia of the lower extremities. The key of the book is the question of "the choice of an anæsthetic" which is cleverly dealt with by the author, who insists that one should render oneself familiar with the physiological action of each anæsthetic, and on that base the method of administering it and avoiding its dangers ; that one should consider the pathological problems arising from the condition of the patient and the shock incident to the surgical procedure, and study which sequence of physiological phenomena will tend to lessen or accelerate the dangers arising from such shock and disease, and then select the anæsthetic which diminishes the dangers and helps the patient. The clear and able way in which important points,

such as the methods of anæsthetisation, what anæsthetic to use, and how to avoid danger, are described and discussed, makes it a hand-book of the utmost value to any practitioner.

DISEASES OF THE NOSE AND THROAT. By J. PRICE-BROWN, M.B., L.R.C.P.E.; Member of the College of Physicians and Surgeons of Ontario; Laryngologist to the Toronto Western Hospital; Laryngologist to the Protestant Orphans' Home; Fellow of the American Laryngological, Rhinological and Otological Society; Member of the British Medical Association, the Pan-American Medical Congress, the Canadian Medical Association, the Ontario Medical Association, &c., &c. Illustrated with 159 engravings, including 6 full-page coloured plates and 9 coloured cuts in the text, many of them original;  $6\frac{1}{4}$  by  $9\frac{1}{4}$  inches; pages xvi., 470, extra cloth, 3 dols. 50 cents, net. The F. A. Davis Co., publishers, 1914-16, Cherry Street, Philadelphia.

This volume will prove of great use to physicians and surgeons in general practice, who require that any work on special branches of professional work, while affording clear and definite directions for treating patients whom it is undesirable or impossible to hand over to a specialist, should be terse and to the point, well arranged and well illustrated, and brought into accordance with the most recent scientific work.

The local anatomy and physiology are discussed only so far as they relate to practical treatment, even as regards the frontal sinus and lacrymal canal the author refrains from trespassing on the field of the oculist, and except as far as naso-pharyngeal disease affects the Eustachian tube, the diseases of the ear are not touched upon. Diphtheria is omitted, but the methods of intubation, tracheotomy and thyrotomy are sufficiently described. The book is well printed, especially as regards the illustrations and coloured



plates, and the full descriptions of the methods of examination and the woodcuts of the armamentarium will prove valuable to the student for practical work or examination purposes.

BIBLIOGRAPHIA MEDICA. INDEX MEDICUS.

French edition, 1900.

The first number of the above-named periodical, which is designed to fill the place of the American *Index Medicus*, now unhappily a thing of the past, appeared on February 15, 1900. The new issue is under the editorship of Dr. Marcel Baudoin, director of the Institute of Bibliography in Paris, and the esteemed direction of Professors Ch. Potain, member of the Institute, and Charles Richet.

As this new publication will have all the advantage of the experience gained by its predecessor, and at its disposal many valuable improvements not available in 1879 when the *Index* first appeared, we may hope that it will contain, while retaining its comprehensive international character, many improvements in detail. It is promised that a number appearing on the 15th of each month will embrace the entire medical literature of all nations for the preceding month classified according to the scheme in the Preface, and it is intended to issue yearly, to subscribers to the entire work only, at a special subscription, indices to the literature of special branches of medical science.

As it takes a thousand double column pages to give merely the titles of the medical works now published in a year, it has been decided not to include the following subjects, which, though related to, are not integral parts of, medical science, viz., anthropology, descriptive zoology and botany, embryogeny, metaphysical psychology and sociology. Moreover, some sacrifices have had to be made in order to bring the annual volume down to 1,000 pages—an æsthetic typography would have taken at least sixteen hundred.

Bibliography, in itself little or nothing, is an indispens-

able beginning to research, and we heartily welcome this important work, as will all who have had occasion to use and appreciate the old *Index Medicus*. At the very moderate price of sixty francs within the postal union, it is certainly worth a place in every medical library.

#### MERCK'S REPORT ON THE YEAR 1899.

From the firm of E. Merck, 16, Jewry Street, we have received an advance copy of the annual report on "New Drugs and Therapeutical Preparations," which they now publish in French and Russian as well as in English (corresponding to vol. xii. of the complete German edition). The immense number of novelties offered to the profession make this report, which contains ample references to the literature of therapeutics, and is by no means merely a trade circular, of great value to the profession, to any member of which it will be sent on application as above. As more particularly interesting to our readers we may mention reference is made to the use of 1·5 grs. suppositories of dionine in dysmenorrhœic and parametric pain in ovaralgia and salpingitis; of eumenol, a fluid extract of a root used from old time in China in irregular and painful menstruation; of a preparation of purified under-fermented yeast adapted for Landau's treatment of leucorrhœa (BRIT. GYN. JOURNAL, vol. xv., 1899, p. 304), the beneficial effects of which have been more recently verified by Muter; of gelatine in metrorrhagia; of argonine largin protargol, &c., in gonorrhœa; of corpora lutea, parotid gland and ovarian substances among organo-therapeutic preparations; and of stypticin as advocated by Zweifel and Dührssen in profuse menstruation, and by Gottschalk and others in climacteric hæmorrhage.

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## PUBLICATIONS RECEIVED.

In addition to books reviewed, we have received too late for detailed notice in this number :—

Practical Gynæcology. By Heywood Smith, M.A., M.D. Second edition, revised and enlarged. London: Henry J. Glaisher, 1900.

Merck's Digest: No. 7, Iodipin and Bromipin; No. 8, Hæmogallol and the Metallic Hæmols.

FR. NEUGEBAUER: 50 Missehen wegen homosexualität der Gatten und einige Ehescheidungen wegen "Erreur de sexe."

FR. NEUGEBAUER: Une nouvelle série de 29 observations d'erreur de sexe (avec 26 figures).

FR. NEUGEBAUER: 17 Fälle von Koincidence von Geistesanomalien mit Pseudohermaprodismus.

S. C. GORDON, Portland, Me.: Common sense in Medicine.

M. D. MANN, M.D.: Experiences in Intestinal Surgery.

MARY A. DIXON JONES, M.D.: Endothelioma of the Ovary.

" " Pelvic Peritonitis.

" " Criminal Abortion.

" " Myxomatous Degeneration of the Ovary.

F. J. HERRGOTT: Revue de "La Pratique des Accouchements." Obstetrique Journalière, par HENRI VARNIER.

## TO CONTRIBUTORS AND SUBSCRIBERS.

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The JOURNAL will be pleased to receive, and to translate at its own expense, contributions by Continental authors written in French, German, Russian, Spanish, Danish, or Italian, if on examination they prove desirable.

ALL COMMUNICATIONS TO THIS JOURNAL, OF ANY NATURE WHATSOEVER, MUST BE CONTRIBUTED TO IT EXCLUSIVELY. THE EDITORS RELY ON ALL CONTRIBUTORS CONFORMING STRICTLY TO THIS RULE.

It is intended to notice in the Summary of Gynæcology such published work of Fellows of the Society and other British gynæcologists as may not appear elsewhere in the JOURNAL, and the Editor will be obliged by receiving a condensed account of any such work, with a reference to the Journal in which it has appeared.

The Editors are not responsible for the views of contributors.

Lithographic Plates or other Illustrations are prepared by arrangement whenever required.

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## NOTICE.

It has been suggested that Friday would be a more convenient day for the meetings of the Society than Thursday, as Saturday is more or less a free day, and Fellows attending the meetings from a distance would not always be compelled to leave London immediately after the meeting. Any expression of opinion on the matter by any Fellow of the Society will be welcome to the Council for consideration at their meeting in June.



# THE BRITISH GYNÆCOLOGICAL JOURNAL.

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*BRITISH GYNÆCOLOGICAL SOCIETY.*

THURSDAY, MAY 10, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

Dr. WALTER (Manchester) showed a myoma removed by enucleation, after vaginal cœliotomy and section of the uterus had been first performed.

The patient, aged 37, was admitted into St. Mary's Hospital, on March 23, 1900. She was in a very anæmic and exhausted condition, having suffered from metrorrhagia for several months. She had had one pregnancy three years previously and the labour was normal. On admission into hospital the cervix was patulous, and a myoma could be felt attached to the anterior wall of the body and fundus, a small portion protruding into the cavity of the uterus, but the greater part of the tumour was flattened and intra-mural.

*Operation on March 27.*—The patient being anæsthetised and the cervix completely dilated with Hegar's dilators, an attempt was made to enucleate the growth in the ordinary

way through the cervical canal, but without success. Vaginal hysterectomy accordingly seemed inevitable, but before resorting to such a measure I performed colpotomy, dividing the anterior wall of cervix and lower segment of uterus; another attempt at enucleation proving futile, I was forced to make a vaginal coeliotomy, and the incision in the uterus was carried right up to the fundus. The myoma was then enucleated without much trouble. The uterine wound was closed with chromic gut, and a gauze drain was left in the uterus for twenty-four hours. The after progress was most satisfactory, and the patient returned home at the end of three weeks.

Dr. WALTER considered that if the attempt at enucleation involved much bruising or laceration of the uterus, or if there were several myomata present, it would be better and less risky to proceed at once with total hysterectomy.

Dr. WALTER mentioned the case of a single woman, aged 45, admitted into St. Mary's Hospital March 20. The abdomen had been enlarging for four to five years, and was still increasing in size. Micturition was frequent and difficult, and metrorrhagia had been troublesome for three years. A large hard mass reaching from the pelvis to one inch above the umbilicus occupied the abdomen, and the vaginal examination showed its uterine origin. Abdominal pan-hysterectomy was performed, a small drain of gauze was left in the vaginal opening. The right ovary was cystic and therefore was extirpated, the left ovary being healthy was not removed. The patient left the hospital at the end of four weeks.

The specimen consisted of a myoma attached to the anterior wall of the uterus, and another springing from the posterior wall, together with several small nodules scattered over the surface of the uterus.

Dr. FRED EDGE (Wolverhampton) showed two specimens of myoma uteri removed by vaginal hysterectomy.

Dr. F. WINSON RAMSAY (Bournemouth), and Dr. ARTHUR GILES showed a uterus with multiple stalked

fibro-cystic tumours invading the broad ligament, illustrated by microscopical preparations.

In the discussion on these specimens—

Dr. CUTHBERT LOCKYER said that a careful examination of the last specimen led him to concur in the view expressed by Dr. Giles, that these remarkable polypoid growths were fibro-cystic in character. He thought that the specimen was unique, as he had never seen or read a description of similar growths invading the broad ligament. The portion of the growth in the uterine wall was relatively soft, whilst the polypoid portions were considerably firmer.

Dr. MACNAUGHTON-JONES, referring to Dr. Walter's specimen of myoma removed by enucleation, said that, except in the case of pedunculated fibroids, he had not removed these tumours by enucleation. But the view put forward by Dr. Walter was now, he thought, coming to be looked on as the right one, especially in America. Howard Kelly, in his book, expressed the opinion that, whenever it was feasible, enucleation was the classical operation for fibroids, and mentioned a considerable number of cases in which he had enucleated the myomata, and preserved the uterus. His own feeling had been otherwise, namely, that in dealing with myomata, the best practice was to remove the uterus. He admitted, however, that the paper read last year before the Society by Dr. Alexander was, in many respects, very convincing.

The PRESIDENT observed that his feeling was that pan-hysterectomy was the best operation for myomata. Enucleation might have to be followed by further operations, and this seemed to him a very undesirable and unfortunate result.

Dr. WALTER, in his reply, said that the scope of enucleation appeared to him to be limited to cases in which the uterus contained one or two tumours. When half-a-dozen or more tumours had to be removed, the uterus was likely to be much injured; and an important objection arose not only from the fact that some of the tumours might be

left behind, but also because of the immediate danger of the operation due to mauling of the uterus. On the other hand, there were cases when after removal of the whole uterus one felt that the growth might easily have been enucleated. In this case he made an effort in the first instance to enucleate; and from the fact that after the preliminary attempt the patient showed no bad symptoms, he felt that there could at least be no harm in trying this plan first in some cases. If a further and more radical operation were needed, all that was necessary was to bisect the uterus and remove it in two halves.

Dr. FRED EDGE said, in reply, that perhaps he was inclined to take an extreme view; but all that one could do was to follow the teachings of one's own experience. In the last three years he had seen in the practice of his colleague, Dr. Christopher Martin, three cases in which malignant disease occurred in the stump of the cervix left after supravaginal hysterectomy; the first operation had in each case been performed by means of clamps, by the late Mr. Lawson Tait. He had himself met with three cases in which a patient had a moderate-sized myoma with but few symptoms, so that he advised against operation; and in each case the patient returned within a short time with malignant disease. These cases had led him to determine that in every case of myoma with at least two or three tumours he would advise and practise the removal of the whole thing by panhysterectomy.

Dr. WINSON RAMSAY and Dr. ARTHUR GILES showed a specimen of ovarian papilloma invading the uterus through the Fallopian tube.

Dr. CUTHBERT LOCKYER said that the growth had apparently passed along the Fallopian tube without forming any attachments to it; but it had formed an attachment to the uterus at one point, burrowing through the mucosa into the parenchyma in that situation.

Dr. WILLIAM WALTER said that this growth appeared to be unique; he would suggest the question whether the



disease could have arisen in the uterus itself? Such a view was supported by the fact of the attachment to one part of the uterus, and by the adenomatous character of the growth.

Dr. HERBERT SNOW considered that there were no vaguer words in pathology than "papilloma" and "adenoma." There was a point about papillomata which he had never been able to understand, and that was why such a growth in one tube should always infect the tube on the opposite side; he had always thought that the channel of infection was formed by the lymphatics. Might not the growth in the uterus in this case have arisen from rupture of the lymphatics in the uterine wall? It was the custom in operating on such cases to remove the diseased appendages and leave the uterus; but the specimen before them pointed to the fact that this practice might leave a considerable part of the disease behind.

Dr. FRED EDGE suggested that this might have been a polypoid growth with a long thin pedicle, arising from the ovary, passing down the tube and effecting an attachment to the uterine wall. Or it might perhaps have started in the ovary and uterus independently.

Dr. MACNAUGHTON-JONES thought that such a specimen pointed to the desirability of having a standing pathological committee, to which all rare and interesting specimens might be referred.

Dr. EDGE remarked that such a committee would be a great boon to the country Fellows of the Society.

Dr. ARTHUR GILES, in reply, said that he agreed with Dr. SNOW as to the vague way in which many terms were used in pathology. He had applied the term papilloma to this growth in reference to its naked-eye form; and the term adenoma in reference to its microscopic characters, which were those of a glandular structure. He further qualified the adenoma as being, in his opinion, malignant, because of the irregular way in which the glands had proliferated and invaded surrounding parts. He thought that Dr. EDGE's first suggestion as to the mode of growth of the tumour was the most probable one.

TWO CASES OF RECTO-VAGINAL EXCISION FOR HIGH RECTAL CANCER. By HERBERT SNOW, M.D.(Lond.), &c. Senior Acting Surgeon to the Cancer Hospital.

CASE I.—Annie C., aged 57, widow, three children, was admitted into the Cancer Hospital on September 26, 1899. She was a well-nourished, physically strong woman, suffering very intense continuous pain in the rectal region. The symptoms were described as of about a year's duration. Apparently the disease had existed for from two to three years. There was the usual history of antecedent trouble and worry; none of injury, or of "cancer in the family." I was informed by the relatives that the private medical attendant had pronounced the case beyond the scope of an operation.

The whole of the bowel was infiltrated as far as the finger could reach; but the upper margin could be felt, especially *per vaginam*, and the mass was mobile, easily pulled down. There was a sanious discharge from both vagina and rectum. The infiltration was hard and brawny—a very important point in such cases, in view both of prognosis and of surgical treatment.

On September 29 the whole growth with the recto-vaginal septum was removed; the latter as high as the posterior fornix. Douglas' pouch was opened, and was subsequently sutured with catgut. The rectal mucous membrane was finally sutured to the skin posteriorly; a large gaping wound in front being plugged with iodoform gauze, and a self-retaining catheter left in.

The patient made an uninterrupted recovery, and was then fitted with a vulcanite plug. She left the hospital in the best of health on January 27 of this year, to all appearance permanently cured, and has remained well to the present time. I am indebted to Dr. T. Johnston English for the photograph exhibited, which shows the condition after cicatrization. The os uteri forms the apex of a deep triangular *cul-de-sac*. The end of the intestine is invisible.

CASE II.—Jane G., aged 57, single, children's nurse,

admitted February 16, 1900. A spare woman with very worn-out look, no injury. Said: "Much worry with troublesome children." No family history of cancer. The disease had existed two or three years, though the stated duration was only eleven months. Here again the patient had been told—this time at a women's hospital—that it was too far gone for operation.

There was a hard woody infiltration involving all but a very narrow strip of mucous membrane. The upper limit could not be reached *per rectum*, but could by the vagina. The whole seemed very mobile, and could easily be dragged down. There was sanious discharge from both canals, and after admission an attack of vaginal hæmorrhage from ulceration just within the vulva.

On February 23 the diseased mass was excised, with the infiltrated recto-vaginal septum to within one eighth inch of the uterus, the *labia minora* and the lateral walls of the vagina. Although previously so mobile, it was found that there was a small strip of infiltrated tissue stretching up beyond the apparent upper margin to the left broad ligament. This was, however, carefully worked down by the left index finger inserted within the gut, and to all appearance completely extirpated. Douglas' pouch was necessarily opened, and as the patient immediately had a bad fit of coughing, most of the small intestine at once protruded. It was returned and kept in place, with the able help of Mr. Sylvester Willard, who was kindly assisting me, by a flat sponge; while the large peritoneal fissure was sewn up with silk. The rectal mucous membrane was sutured to the skin posteriorly, the huge cavity in front being packed with iodoform gauze, and a catheter left in.

The patient never had the slightest bad symptom. The specimen is exhibited, and with it a photograph of the cicatrising chasm on the twenty-second day after operation. The intestinal mucous membrane is seen at the posterior angle of the wound; a circumstance rather exceptional, though distinctly advantageous. The temperature - chart

shows the favourable convalescence and proves the absence of shock after a severe operation.

*Remarks.*—There are two points in connection with these cases which I desire specially to submit for consideration. The first is that both were passed by—one at a special hospital, the other by a private doctor—as wholly beyond the reach of operative measures. I imagine that the profession at large has hardly yet learnt to regard the higher regions of the rectum as lying within the scope of practical surgery. Yet so long as the gut remains mobile, cancerous disease of very long standing can be here removed; and, as in the infiltration, which appears “woody” to the touch, secondary deposits occur but tardily, can often be permanently eradicated. The female sex has in this matter an important advantage over the male, seeing that the bladder is so much less prone to infiltration.

The second point is that, by manipulation, the dissected part can nearly always be brought down and safely excised, without any interference with the bony structures. Personally, I have never yet seen a case of rectal cancer wherein excision was feasible at all, which could not be satisfactorily dealt with in the manner above indicated, without resort to the heroic operations of Kraske, Madelung and their numerous imitators. I should be sorry to lay this down, however, as a rule without exception; and I only venture to suggest it with the utmost respect for the surgical skill of those fellows of the Society who, to my knowledge, most ably perform those operations.

Mr. CHARLES RYALL congratulated Dr. Snow on the results of his two cases. As far as prognosis was concerned, the surgery of cancer of the rectum was hopeful. As to the method adopted by Dr. Snow, he would point out that there were many cases of cancer of the upper part of the rectum which could not be dealt with without removal of the bony parts. In a case he had reported at the British Medical Association, twelve inches of the upper rectum and sigmoid were removed. This operation had the further advantage that one had not to work in the dark.



Dr. WINSON RAMSAY raised the question whether it was better to leave the opening of the bowel below, or to perform an inguinal colotomy. He believed that the latter was much more comfortable for the patient. In a case in which he had to remove the greater part of the lower bowel he adopted the plan of doing an inguinal colotomy first.

Dr. HERBERT SNOW, in reply, said that he was sure that there were many cases in which the growth could be removed without touching the bony structures, as long as the rectum was mobile and could be brought down. He had a great prejudice against inguinal colotomy, because he had seen five or six deaths from it. He much preferred lumbar colotomy, because by that means they could get at least two inches higher up the bowel, and also because the operation was far safer.

Dr. HERBERT SNOW exhibited a uterus removed by vaginal hysterectomy for cancer of the cervix. The patient was a young married woman, aged thirty, and the disease was of three months' duration. The specimen illustrated the early and favourable stage of carcinoma at which alone a radical cure might reasonably be anticipated from the operation. It was useless to operate when there was infiltration of the vaginal *sub mucosa*, or broad ligaments. The woman now had excellent health, but displayed a condition Dr. Snow had not met with previously. There was a soft, fleshy knuckle of omentum, embedded in the vaginal cicatrix, and from this about a drachm of clear, non-odorous fluid exuded every morning.

ON THE INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES. By J. MACPHERSON LAWRIE, M.D., Physician to the Weymouth Sanatorium; Vice-President of the British Gynæcological Society.

IN the treatment of pathological conditions of the pelvic organs in women, the question of the removal of the uterine appendages is one which is often raised. The old headlong

surgery of twenty years ago, when the ovaries and tubes were extirpated on the slightest provocation, has given place to a reaction in favour of extreme conservatism. I believe that the tendency has been a healthy one; indeed some such reaction was necessary in order to save gynæcology from a reproach which was fast becoming one of very great gravity. In some quarters the pendulum has swung to the far end of its excursion, as so often happens; and it has not yet quite settled down to small oscillations about its centre of rest. In this short paper I wish to offer a contribution to the question based upon my experience during the last four years. In this time I have removed the ovaries and tubes for various reasons in 43 cases; the full notes of all these have already been given in two papers read before the British Medical Association, in 1897 and 1899, and it will not therefore be necessary to trouble you with them here. I shall content myself with making such references to them as may be necessary for the elucidation of my subject.

I do not propose to consider here operations for the removal of ovarian or broad ligament cysts or solid growths; for these belong to a different category, in which there is no difference of opinion as to the indications for operation. For the purpose of discussion and to elicit opinions, I wish to tread upon debateable ground.

My subject, then, is the removal of the appendages for the following indications:—(1) Non-suppurative salpingitis; (2) chronic ovaritis; (3) small cystic ovaries; (4) pyosalpinx; (5) suppurating ovarian cysts; (6) uterine fibromyoma; (7) tubal pregnancy.

The first three conditions are so often found associated that it will be convenient to consider them in one group, and the same remark applies to the fourth and fifth indications. This gives four groups of cases in which I have operated as follows:—

CASES.

A. For salpingitis, ovaritis, and cystic ovaries...	32
B. For pyosalpinx and suppurating ovarian cysts	6
C. For uterine fibro-myoma ... ..	3
D. For tubal pregnancy ... ..	2

*Group A.—Removal of the Appendages for Salpingitis, Ovaritis, and Cystic Ovaries, i.e., for Non-Suppurating Diseases of the Tubes and Ovaries.*

The clinical picture of a case of this kind is somewhat as follows: The patient is usually about 30 to 35; the average age of my cases was 32·7, there being nine under 30, nineteen between 30 and 40, and four above 40. The majority of patients are married, the proportion among my cases being nineteen married to thirteen single. The great feature that all the cases have in common is pain of several years' duration; this takes the form of severe dysmenorrhœa, and of a gnawing, aching pain in the intermenstrual periods referred to the iliac regions, worse on standing, walking or exertion of any kind. The patient's general condition is one of constant ill-health incapacitating her from attending to her employment or her household duties. She is nearly always pale and emaciated, and in fact she is a chronic invalid. A particularly distressing symptom is a profuse and constant leucorrhœa. If married, we find in addition that the patient suffers from dyspareunia, that she has been sterile for many years, or perhaps has never borne any children; in other cases two or three children have been borne in the early years of married life, and the patient dates her troubles from her last confinement. The quantity of the menstrual loss has no constant characters, in some cases it is excessive, in others it is scanty.

Now, what are we to do with these patients? We counsel much rest; we adopt palliative measures, hot douches, glycerine tampons, and so forth, with a view to reducing uterine and ovarian congestion; we prescribe purgatives, regulate the diet, and insist on a generally hygienic mode of life. Well, I am bound to say that in the majority

of cases such improvement as there is can only be described as slight and temporary ; I have made it an invariable rule to give palliative treatment a fair trial before advising radical measures, but the results have been, on the whole, disappointing. As a rule, the patient gets worse rather than better in the course of time ; she is always disabled, always suffering ; and if she was not hysterical to start with she is likely to become so ; whilst the husband is likely to complain, not unnaturally, that his wife is "always in the doctor's hands." Under these circumstances, our duty seems to be clearly to remove the offending organ or organs, and restore the patient to health.

This is a matter on which authorities are not by any means agreed. If they were, there would, perhaps, be little need for me to bring the subject before you to-night. Some say, "These patients are hysterical, and no operation will cure them"; others consider that time is all that is necessary to effect a cure ; some argue that the condition is not one that destroys life, and, therefore, no operation is warranted ; lastly, it is urged that the ovaries and tubes in these cases are not unhealthy, and ought not, therefore, to be removed under any circumstances.

It is true that some of these patients are hysterical ; but as I have said, the hysteria is often the effect and not the cause of her sufferings ; but whether hysterical or not, my experience is that an operation does bring about a cure, usually completely and permanently. Nor does my experience stand alone ; it is that of many others. It will be sufficient for me to recall the recent paper by Mr. Furneaux Jordan, in which the satisfactory results of operations for the removal of the appendages are given.

With regard to the view that time will effect a cure, I may remark that in many of my cases time had had every chance of doing so, aided by palliative measures of all kinds, but without success. Supposing, however, that it were granted for the sake of argument, that two or three years of rest alternated with change of air and scene,



together with hygienic measures, treatment at spas, sea-voyages, &c., would cure these patients, we should be still confronted with the question, In what proportion of cases can this costly and prolonged treatment be carried out? In but a small proportion, certainly, for many of these patients have to earn their living, and if not otherwise succoured, would starve before they were cured. Even with the wealthier classes, non-operation means usually postponement of operation; and if operation has to be resorted to, it may as well be done first as last, and all the intermediate suffering be dispensed with.

The argument that interference is not warranted because the condition is not one that threatens life is largely met by what has just been said. I may, however, remark further that in these days of safe operating many operations of expediency are permissible that would be contraindicated if the risk were greater. It is only necessary to mention plastic operations for the cure of deformities, radical cure of hernia, operations for dysmenorrhœa, &c. Among my 43 cases there was one death only; and this one is to be attributed, not to the operation itself, but to the fact that she had not been operated on earlier, for she had got into a wretchedly poor condition, and in consequence did not rally from the operation.

Lastly, we have the argument that the ovaries and tubes in these cases are not diseased, or at least that they are not sufficiently diseased to require removal. I am convinced, from a careful examination of the organs after removal in my cases, that this view is erroneous. As a rule the ovaries were found to be enlarged and cystic, sometimes to a really considerable extent; the tubes often showed evidences of salpingitis, and in some cases were in the condition of hydrosalpinx. In another class of cases the ovaries were cirrhotic though not enlarged; and the careful work of Dr. Mary Dixon Jones, in America, has demonstrated that many of these ovaries are the seat of the conditions which she has described as endothelioma, gyroma and colloid

degeneration. The almost constant sterility in these cases also shows that such ovaries are at least too far diseased to carry out their proper functions of healthy ovulation. We have yet to consider the question of conservative surgery in these cases. Much has been written on this subject of late years ; indeed, we have had a communication from one of our own Fellows, Mr. Christopher Martin. While granting at once that there is much to be said in favour of puncture and ignipuncture of small cysts, resection of ovaries and tubes, &c., it is also true that there is much to be said on the other side. Ovaries so preserved are fundamentally unhealthy, and the recorded cases in which such partial operations have been followed by pregnancy must be set off against the probably more numerous cases where a second operation has had to be performed later on. One of my cases is an instance of the disadvantage of incomplete operation, for it was one in which the abdomen had to be opened a second time, for the removal of an ovary and tube left behind at the first operation, in the hope that the patient might be spared the necessity of double oöphorectomy. Moreover, these partial operations are not by any means always followed by relief of symptoms ; and what these patients require above all, is not the preservation of this or that organ, but relief from their sufferings, and restoration to a condition of health and usefulness. This much they have the right to demand of us, and this we must give them.

*Group B.—Removal of the Appendages for Pyo-salpinx and Suppurating Ovarian Cysts.*

Under this category all the patients recovered. There is no question in dealing with this class of case as to whether an operation should be done or not, for it is universally agreed that the diseased appendages must be dealt with surgically. This shows how rapidly opinions may change as to the indications for operation ; it is only about seven years since Cullingworth read a paper at a

sister society advocating abdominal section in cases of suppurative pelvic inflammation, and on that occasion considerable opposition was offered to his views by certain authorities in the obstetrical world. At the present time such opposition would be regarded as retrograde conservatism, and if it is still felt, it is not shown. The main question at issue to-day is as to the best method of attacking these conditions. Of late it has been strongly urged that collections of pus should be approached from the vaginal side ; this course has been advocated quite recently at our meetings by such experienced operators as Mr. J. W. Taylor and Mr. Furneaux Jordan. I quite concur in the view that there are some cases in which the vaginal is the best route ; notably those in which the appendages are bound down in the midst of a dense mass of adhesions, and there is a strong probability of coils of intestine being involved. If then fluctuation can be felt through the vaginal vault readily, or even fairly so, I think that the pus-sacs should be tapped vaginally. It is in such cases that the vaginal radical operation has been advocated, the uterus being first removed to make room for the removal of the appendages, and also for the reason that it is irremediably diseased and likely to act as a focus of further mischief. With this view I cannot agree ; it seems to me better to simply tap and drain ; and if the appendages have to be removed, it is better to do this operation through the abdomen. My reason for this is that in any case of suppurative disease of the appendages there are likely to be some adhesions which may or may not involve the intestine ; and these can be dealt with much more safely and effectively with the fuller view obtained by abdominal section. In the class of cases which I have described above, as suitable for tapping through the vagina, the appendages are left, on account of the difficulty and risk which would attend any attempt to remove them ; but in cases in which the fixation is not so marked, and in which no fluctuation can be detected vaginally, I should advocate the removal of the appendages by the abdominal route, for

the reasons I have given, and also because they should not be left behind if this can be helped. The dangers of this course have been dwelt upon by various surgeons, the principal ones being the risk of wounds of the intestine followed by intestinal fistula, and the risk of fouling of the peritoneum by rupture of pus-sacs during the process of removal. Both dangers are, of course real; but it is possible, in my opinion, to unduly magnify them. If due care be exercised in the separation of the adhesions, perforation of the intestine can usually be avoided, especially if this be done with the aid of sight, and if, when the adhesions are very firm, the separation be made from the inflammatory mass rather than from the intestine itself. In the same way, the premature rupture of pus-sacs can usually be avoided by enucleating them carefully; whilst even if rupture takes place, in spite of all precautions, no great harm necessarily results, because the pus is sterile in a large proportion of cases, and careful swabbing will usually avert the bad effects of even active pus. Let it, however, be understood that in saying this I am not advocating the slightest relaxation of care in endeavouring to enucleate these pus-sacs entire. On the contrary, no precaution can be too minute.

*Group C.—Removal of the Appendages for Uterine Fibromyoma.*

Among my 43 cases of the removal of the appendages, there were 3 in which the operation was done for uterine myoma. In former years this proportion would probably have been larger, but at the present time hysterectomy has largely taken the place of oöphorectomy. In some quarters, indeed, oöphorectomy for myoma is relegated to the category of obsolete procedures, on the principle that the diseased organ should be removed and the healthy ones left. With this general principle I agree; there are, nevertheless, in my opinion, cases in which oöphorectomy



is not only a permissible, but even the best operation. Such cases fall into two classes—first, cases in which the tumour is small and the appendages are unhealthy ; secondly, cases in which the patient is in a very enfeebled condition through profuse hæmorrhage. The first indication was present in two of my patients ; the uterus in both instances was only moderately enlarged, whilst the ovaries were enlarged and cystic. The latter required removal in any case ; consequently, it seemed advisable to try to secure the diminution in size of the myoma by oöphorectomy, without submitting the patient to the graver risk of hysterectomy. The result has in each case fully justified the procedure, as both patients have been completely relieved of all their symptoms, and the tumour has been found diminished in size. Mr. Furneaux Jordan recorded similar good results in the paper which he read recently before the Society. The second indication—viz., profuse bleeding, leading to great prostration of the patient—led me to adopt the plan in my remaining case. In the paper I have referred to, Mr. Jordan points out that in these patients whose recuperative powers are at the lowest ebb, hysterectomy might just turn the scale against the recovery of the patient ; whilst if a second operation of hysterectomy is required later on, it can be done under much more favourable conditions, so that the fact of a second operation being required cannot be here advanced as a weighty argument against oöphorectomy. It is better to operate twice and save the patient than to lose her by a more brilliant first operation. There are, of course, cases of myoma in which oöphorectomy would be in any case unsuitable, or at least would have to be regarded as merely palliative ; such are cases of very large tumours, of fibro-cystic myomata, and of tumours causing severe pressure symptoms. For these, hysterectomy is the only means of cure.

*Group D.—Removal of the Appendages for Tubal Pregnancy.*

This is included here for the sake of completeness, not because there is any divergence of opinion on the matter. Two of my cases were operations for ectopic gestation, and both recovered. It is not usually necessary to remove the appendages of both sides, unless obviously diseased, for there is no predisposition to recurrence of this accident, and on the other hand, the patient may subsequently become normally pregnant, and we should not without special reason, prevent this possibility.

I do not propose to enter here on the question of neurosis as an indication for oöphorectomy, for the simple reason that I do not consider it to be such. It is the practically unanimous experience of a large body of operators in former years that the operation is not only ineffectual for the cure of neurosis, but actually harmful. I take it to be a matter of general agreement that it is in this department that abuses have existed which have tended to bring discredit upon the operation.

In conclusion, I may sum up the views expressed in this paper by saying that I believe that the ovaries and tubes require to be removed in the following conditions: Chronic ovaritis, salpingitis and cystic disease of the ovaries, when palliative methods have failed to afford relief; suppurative diseases of the ovaries and tubes, *i.e.*, pyosalpinx, tubo-ovarian and ovarian abscess; fibro-myoma of the uterus of moderate size, either when the ovaries are diseased, or when the patient has been so debilitated by prolonged hæmorrhage that hysterectomy would be specially risky; and in cases of tubal pregnancy. Mere neurosis, apart from organic disease is not to be regarded as an indication for oöphorectomy under any circumstances. Further, I believe, that mere puncture and resection of the ovaries and tubes is in most cases inefficient and unsatisfactory, and that for pyosalpinx, the abdominal is usually preferable to the vaginal route.

*BRITISH GYNÆCOLOGICAL SOCIETY.*

THURSDAY, JUNE 14, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

## A CASE OF FIBRO-MYOMA OF UTERUS. By Dr. W. H. A. NEWNHAM, of Bristol.

THE weight of this specimen is 14 lbs. 11 ozs. The patient was a woman, aged 24, who had been married for four years, but had had no children. The catamenia commenced at the age of 15, were always very profuse, lasting seven days, and the patient had to spend seven days in each month in bed. She had only noticed this tumour for two years. On admission to the hospital Dr. Newnham found that she had a large solid tumour filling up the abdomen, and reaching up to the ensiform cartilage.

On May 8, 1900, he removed the tumour by intra-peritoneal hysterectomy; he had no difficulty except that he could not tie the uterine arteries until he had removed the tumour. She did not have a single bad symptom, the next morning (or twenty-four hours after the operation) she was reading a book in bed. She was discharged from hospital well on June 5, 1900, or twenty-eight days after the operation.

## TWO DERMOID OVARIAN TUMOURS. By Dr. G. ELDER, of Nottingham.

These specimens were removed from a patient, aged 29, on May 14, 1900. She had recently been married, and was seized with severe abdominal pain and fainting on March 27, and had to be carried to bed, where she remained mostly

till the date of operation. She developed symptoms of peritonitis, for which her medical attendant employed hot applications, blisters, opium, &c., with but little effect. When seen by Dr. Elder she had a somewhat tympanitic belly with free fluid, great tenderness, rapid pulse, 120, and a temperature 101°. *Per vaginam* the uterus was felt easily, and what seemed to be the left ovary and tube adherent to posterior surface of uterus much enlarged and exquisitely sensitive. On account of patient's grave condition and its evident pelvic origin, a further examination was not made, and abdominal section advised. This was done on May 14, and the following condition of things was found: Peritoneum was so thick that it seemed more like a cyst wall than what we usually find, and adherent to its upper surface were coils of small bowel. A large quantity of foul sero-purulent fluid, greasy in part, with several strains of hair floating in it, flowed out of the peritoneal opening; and from loose adhesions to bowel, uterus, pelvic tissues, the longer (right) tumour was enucleated, which had evidently burst, and from the vent there protruded a coil of hair quite 4 ins. in length. The pedicle had become twisted once round. This was secured in the usual way, and the tumour, as large as a foetal head at term, removed.

Deep down in Douglas' pouch, surrounded by adhesions, the left ovary—also a dermoid—was found, brought to the surface, and removed. This tumour was of the size of a Tangerine orange.

The cavity was drained for twenty-four hours, and the patient made an uneventful recovery.

#### CARD SPECIMENS.

The following specimens, removed by posterior vaginal cœliotomy were shown by Mr. J. Furneaux Jordan.

(1) Left Fallopian tube. There was a long history of recurrent attacks of pelvic peritonitis, the tube was thickened to the size of the finger, very adherent, and the abdominal



ostium completely occluded. Date of operation, September 29, 1899.

(2) Both Fallopian tubes—history of gonorrhœa dating back for twelve months—both tubes elongated, dilated and tortuous, both the abdominal ostia occluded. The tubes were very adherent and were with difficulty removed. Both pedicles were clamped with Doyen's forceps. Operation on January 17, 1900.

(3) Right tubal pregnancy. In addition to the tube shown, a large intraperitoneal hæmatocele was evacuated and washed out. Operation, February 17, 1900.

(4) Cystoma of left ovary. This was a cyst containing a pint and a half of clear fluid. After it was tapped the cyst wall was easily pulled through the vaginal incision and the pedicle ligatured. Operation on February 22, 1900.

(5) Cystoma of right ovary—about the size of a large orange. On pulling the cyst down after tapping it was found to be adherent to the back of the broad ligament; after separating these adhesions there was no further difficulty. The pedicle was ligatured. In this case and in No. 4 no drainage was used, the incision into Douglas' pouch being sewn up. Operation on March 9, 1900.

(6) Columnar celled carcinoma of ovary. This was a tumour of the ovary—about the size of a coca-nut and occupying the pelvis behind the uterus. Microscopically it proved to be a columnar celled carcinoma. Operation on May 2, 1900.

(7) Left tubal pregnancy with large intraperitoneal hæmatocele. This was a case of early tubal pregnancy—about seven weeks—hæmorrhage from the tube had continued for about ten days before operation which was on June 10, 1900.

All the patients have made good recoveries—the last one being convalescent.

THE INDICATIONS FOR THE REMOVAL OF THE UTERINE  
APPENDAGES.

The discussion of Dr. Macpherson Lawrie's paper on this subject, which was adjourned from the May meeting, was opened by the following communication from Dr. Macnaughton-Jones (who was unable to be present), to the author :—" I regret much that I am prevented from taking part in the discussion on the important subject dealt with in your paper. With regard to your conclusions as to the grounds that justify removal of the adnexa, I may say that I am generally in accord with them, I suppose that the teaching of modern gynæcology is practically unanimous in the instance of any extensive pelvic suppuration involving the ovary and tube of one or both sides ; (a) in cases of disease of the oviduct, suppurative, cystic, or other, destroying its integrity and obliterating its lumen ; (b) in blood cysts, both of the ovaries and Fallopian tubes ; (c) in certain solid tumours of the ovary, both malignant and non-malignant ; and (d) in the majority of cases of ectopic gestation. On the borderland of such conditions there will ever be a pathological area, in which we can only determine the course to pursue by the individual nature of, and the complications associated with, the diseased condition we find within it. Nor, indeed, is it desirable that by any hard and fast survey of what must be, until explored in each particular case, a *terra incognita*, we should attempt the impossible, and by any general rule hamper or restrict procedures which are best left to the discretion of the operator at the time. Debatable questions are those raised by you on the extent to which conservative surgery of the adnexa may be pushed with safety to the woman, the influence of salpingo-oöphorectomy on bleeding fibromyoma, and the justification for the operation for various subjective symptoms, and in a certain class of patient in whom a train of nervous phenomena, physical or mental, is associated with affections of the adnexa. This opens

a large question, each section of which would demand careful and unbiassed consideration. I think in the case of fibro-myoma you have put the position fairly, though in view of what may be done by enucleation, either by cœliotomy or colpotomy, with or without resection of the ovaries, we are still further limiting the number of cases in which removal of the adnexa will be practised for bleeding or growing myomata. As to that very large number of sufferers from reflex troubles and nervous conditions, in whom we find or do not find gross changes in the genitalia, it has to be remembered that it has often been demonstrated and proved that the pathological changes found in the ovaries and tubes, though not apparently of great importance on examination beforehand, have been of a most grave character, incurable in their nature, and therefore wrong to leave unremoved. While, therefore, deprecating the removal of adnexa, in which incurable degenerations have not occurred, and where conservative surgery might be expected to place the woman in a safe condition for her future life, we must recollect the frequency with which secondary degenerations occur, and the utter uselessness for procreative purposes of the majority of such adnexa. I take it that your contention is in accord with that of nearly all gynæcological teaching, that on the general question of removal of the entire or part of the internal genitalia, such removal is not to be considered save, first, where other therapeutical steps have either been tried and proved valueless, or the procrastination involved in resorting to them is both directly and indirectly dangerous to the woman, and also where the risk run in operation is less than that to be taken by non-interference. As to the often fought out question as to route, seeing that it is clear that some cases may be most readily dealt with, and certainly with less risk, by colpotomy, and others, even if the operative risk be slightly increased, by cœliotomy, here again I think it is vain to endeavour to formulate conditions which shall be universally applicable. Those which are to be dealt

with by either route have fairly clear indications in their nature and complications sufficient to guide or influence the selection of the route. Surgery is advancing not on the lines of definitions and limitations, whether pathological or operative, and certainly experience generally does not tend to show that in the face of radically altered structures, incomplete, quasi-curative, and expectant procedures, are, in their ultimate issues, satisfactory."

Dr. C. H. F. ROUTH said that he strongly opposed heroic surgery of the uterine appendages. It would be within the recollection of the Fellows of the Society that he read a paper on the subject summarising not only his own views but also the opinions of all leading authorities. That paper was read at a time when the tendency to operate was very great, but since then the tendency had fallen to a great extent. Dr. Macpherson Lawrie's paper was a going back on the question. For himself he took exception to some of Dr. Lawrie's conclusions. Thus with regard to the cases summed up in the paper as Group "A," he denied that inflammation of the appendages was any ground for their removal, any more than would be the case with the liver. He had had many of these cases, and except in one instance he had never agreed to removal. In the instance in question the tumour ruptured during extraction, pus escaped, and the patient died. If a patient had a tumour in the neck, he would not at once proceed to remove it, but would apply leeches, blisters, &c., and the tumour would probably get smaller. Why should they not apply the same principles to the treatment of the diseases of women? His own plan was to first aspirate the tumour, and then inject iodine. They had no right to injure a woman for the sake of an operation. Again, if a woman had pain in the ovaries, they had no right to remove the ovaries any more than they had a right to remove a man's testicles on account of pain, they should apply leeches or blisters, divide the cervix uteri and bleed it, do curetting, &c. Removal of the ovaries altered the frame of the woman's mind, and tended to insanity. They



should also remember that many of the symptoms presented by these patients might occur without any lesion being present. Dr. Kingston Fowler collected notes of 841 autopsies, and of that number only 15 cases had disease of the ovaries. The difficulty of diagnosis was another reason for not operating; for there were many cases that might seem to be suitable for operation, and that might nevertheless be cured by milder measures.

Dr. G. ELDER (Nottingham), thought that the Fellows of the Society ought to feel greatly indebted to Dr. Macpherson Lawrie for bringing such an important paper before them. None of them doubted the propriety of extirpating the appendages for pyosalpinx, suppurating ovaries, extrauterine gestation and tumours, and some of them believed in removing the ovaries for myoma in certain cases; he had himself had several such. But with regard to Dr. Lawrie's group "A," there were grounds for discussion. When the late Lawson Tait had the inspiration to remove the ovaries and tubes in the case of inflammatory conditions, it was a great advance on previous methods; no doubt many ovaries and tubes were subsequently removed that ought to have been allowed to remain; probably most of those present had removed ovaries which on after-consideration they would have left inside. This was formerly; and as for himself, what made him reconsider the matter was the fact that in some instances after the removal of the appendages the pain was no better than before, and the patient had been exposed to a serious operation for no good. In many cases it was very difficult to know what to do; the patient, perhaps, went on from month to month without improvement, and it was perhaps difficult to desist from operation. His own practice now in doubtful cases was always to examine the patient under an anæsthetic, and, if necessary, to make an exploratory incision. If the ovaries appeared to be healthy he left them; in other cases he resected any unhealthy portions. Certainly the general rule of operators was now to leave as much as possible.

Mr. STANMORE BISHOP (Manchester), said that while he would wish to be acquitted of any desire to impede the progress of surgery, there were yet some statements in the paper that were open to debate. Thus Dr. Lawrie said "What these patients require above all is not the preservation of this or that organ, but relief from their suffering; this much they have a right to demand, and this much it is our duty to grant them." This statement, it seemed to him, went too far, or not far enough. Patients also had a right to demand that they should not be transferred from the frying-pan into the fire. Inflammation of a Fallopian tube was not a valid ground for its removal. He also took exception to Dr. Lawrie's recommendation that a pyosalpinx should be tapped and drained. Did the author mean that he would evacuate the pyosalpinx by means of a trocar? If so, it would fill up again. A free incision was alone efficacious. Dr. Lawrie gave two classes of cases of myoma where he advocated oöphorectomy: first, when the myoma was small and the appendages were diseased; and secondly, when the patient was weakened by hæmorrhage. In the first case, he presumed that Dr. Lawrie removed the appendages because they were diseased, and not on account of the presence of the myoma. In the second case, he would point out that in many instances the removal of the ovaries was not enough to control the hæmorrhage. And as to the statement that a second operation for the removal of the uterus could be performed, his own view was that a second operation was always bad for the patient.

Mr. FURNEAUX JORDAN (Birmingham), agreed with the greater part of the paper. Dr. Elder had, he thought, put the matter in a nut-shell when he said that the discussion would turn mainly on the justifiability of removing the appendages in Class "A." Dr. Lawrie thought that the conservative reaction had gone too far; for his own part, he did not believe that this was possible. As long as the operation was aseptic, any conservative procedure could be safely done. In one case of pyosalpinx he incised and

washed out the tubes with a good result ; in another case of cystic ovaries he removed one ovary, and dealt with the other by ignipuncture, and this patient bore a healthy, living child twelve months later. They must recognise, however, that the advocates of removal of the appendages for inflammation did not urge this treatment for every case, but only when the conditions were such as to endanger the life of the patient ; and every such case must be judged individually. When pain was the chief symptom complained of, the patient was often well nourished, and in such cases, especially if the appendages were not enlarged, no operation should be done. He would go further and say that in no case should appendages be removed unless they were palpably diseased. For the determination of this point an exploratory incision was often valuable. With regard to oöphorectomy for myoma, Dr. Lawrie had accurately expressed his own views ; if the patient was much blanched and enfeebled, hysterectomy might be too severe, for even if it were granted that the mortality of hysterectomy was not greater than that of oöphorectomy, there was no doubt that the former was a longer operation. If a second operation were needed, the patient meanwhile attained a better condition for going through it, for even if hæmorrhage recurred after oöphorectomy, it seldom recurred until after several months, and he could testify that under these circumstances hysterectomy was really an easier operation, for he had done it three times after a previous oöphorectomy.

Mr. J. BLAND SUTTON said : " I was greatly interested in Dr. Macpherson Lawrie's very practical paper. It is important to observe how much the operation has become limited in the last five years. From the beginning of my surgical career I have always acted upon one rule, never to remove Fallopian tubes and ovaries unless there was very tangible evidence of disease in these structures. Increased experience has taught me to limit the removal of tubes and ovaries to two sets of conditions, namely, inflammatory lesions and tubal pregnancy.

Under the title of inflammatory lesions of the tubes and ovaries I include *chronic* salpingitis secondary to septic endometritis, whether due to gonorrhœa or septic infection occurring as a sequel to labour or abortion, and tuberculosis of the tubes. Chronic salpingitis calls for operative treatment in three forms :—(1) the large thin-walled and often stinking pyosalpinx ; (2) the sclerosed tube closely adherent to or actually communicating with a small cyst or abscess in the ovary (tubo-ovarian abscess) ; and (3) the thin-walled hydrosalpinx. These three groups of inflammatory tubal disease are the commonest conditions for which double oöphorectomy is required, and they constitute three-fourths of the cases in Dr. Macpherson Lawrie's list.

I requested Dr. Victor Bonney, who has acted for more than two years as the resident medical officer at the Chelsea Hospital for Women, to draw up a list of the cases in which I have performed oöphorectomy since I was appointed surgeon to that institution.

The total number from November, 1895, to the end of May, 1900, amounted to 94. The majority of these operations have been undertaken for the consequences of septic infection occurring as a sequel to endometritis, set up by gonorrhœa or due to sepsis following labour at term or a miscarriage, and 12 were performed for tubal pregnancy.

I have made a comparison of the proportion of cases of infective tubal disease in hospital and in private practice. It is remarkable that in the hospital the proportion of tubal cases is three times greater than in private practice, and this I believe to be due to the following causes :—Harlots take less care of their genitals than well-to-do courtesans, and the wives of the poor do not receive the same careful obstetric nursing as the wives of the rich.

In regard to the value of oöphorectomy in neurotics I cannot say anything for I have never operated under such conditions, and a study of the remarkable "symposium" published in 1886 by Spencer Wells, Hegar and Battey has satisfied me of the futility of the proceeding. I also



strongly deprecate removal of the ovaries for dysmenorrhœa. The fact that gynæcologists realise that the ovaries fulfil other duties than supplying ova has induced operators to be still more careful in regard to the complete removal of ovaries. I do not believe that gynæcologists fully realise how difficult it is to completely remove inflamed ovaries, and I have demonstrated on several occasions where it has been necessary to perform a second operation, the stump left after the primary oöphorectomy to be surmounted by a rounded piece of ovarian tissue which contained follicles and clearly fulfilled ovarian functions for it contained corpora lutea. This might help to explain some of the few anomalous cases where an operator believes that he has completely removed both ovaries yet the woman subsequently becomes pregnant.

I am surprised that Dr. Lawrie advocates the removal of the ovaries for the relief of uterine fibroids, for that operation, like the still more unsatisfactory one of double oöphorectomy for the relief of mammary cancer, is rapidly being banished from the domain of legitimate surgery. I feel a certain amount of pride in stating that the numerous consecutive abdominal oöphorectomies in the subjoined table were performed without death, and I believe that I owe this success to thorough asepsis, abstention from irrigation, and the substitution of a narrow strip of sterilised gauze for the drainage tube. In five of the cases in the table the tubes, ovaries, and uterus were so bound together that it was necessary to remove the uterus. In a great number of the cases the purulent contents of the tubes were submitted to careful bacteriological examination. In a large majority of the specimens the pus was sterile, but it came out very strongly in the inquiry that although the pus was free of micro-organisms, these little bodies were often found scattered in the tubal tissues. My results in private practice have been as good as those at the Chelsea Hospital for Women, but I have restricted the table to hospital cases, as they can be easily verified.

Dr. Victor Bonney has drawn up for me a table of ninety-four consecutive operations for chronic salpingitis, pyosalpinx, hydrosalpinx, tubercular salpingitis, and tubal pregnancy, performed by me at the Chelsea Hospital for Women (see p.p. 142-4).

Mr. F. BOWREMAN JESSETT, after thanking Dr. Lawrie for his important paper, said that he thought that Dr. Lawrie's attitude had not been well understood. It had been assumed that he advocated operation in all cases ; whereas he specified that it should be restricted to cases of incapacity where other methods had failed ; and for his own part he agreed with Dr. Lawrie that if the operation restored the patient to health, it was justifiable. It was true that there were cases in which no improvement resulted. Dr. Mary Dixon Jones had shown that there were cases in which the ovaries presented no enlargement and yet were much diseased ; and he imagined that some of Dr. Lawrie's cases came under this category. With regard to pyosalpinx, it seemed to him that to tap and inject iodine would be much more risky than to remove the tubes through the abdomen. Among other risks, the sac might contract after evacuation, with the result that the iodine was injected into the peritoneal cavity. He agreed with Mr. Furneaux Jordan's views as to the indications for removing the ovaries in cases of myoma.

Dr. ROUTH remarked that he had used his plan of injecting iodine in many cases and had never lost a patient.

Mr. SKENE KEITH said that he was a conservative surgeon, and often relied on conservative methods, such as electricity, which some of his fellow-surgeons appeared to taboo. He did not believe in removing ovaries from a patient in perfect health. There was a condition of ovaries to which no reference had been made, in which the ovary appeared healthy on the surface, but on cutting it open there was a thick capsule almost as hard as cartilage. With each recurrence of ovulation much pain must necessarily result, and the patient became emaciated. If the general

health of a patient was not thus affected, it was not time to operate. He would be afraid to adopt Dr. Routh's plan ; but he had had good results from painting with iodine. He did not think that insanity was common after oöphorectomy ; but he had not infrequently known the operation to be followed by changes of temper. He did not agree with Mr. Bland Sutton as to oöphorectomy for myoma ; if the whole of the ovaries were removed, he would guarantee cure of the hæmorrhage.

Dr. FRED EDGE thanked Dr. Macpherson Lawrie for his valuable paper. As regards the cases grouped under "A," there could never be, from the nature of things, any certainty ; and difficulty must always exist as to how bad the patient really was, how far the general medical treatment had been carried out, and to what extent the patient's usually limited mental conception had grasped the nature of the operation. It was also to be remembered that the after-condition was not always perfect. He did not refer to the effects of removal of the ovaries and tubes, but to the pains and aches and trouble following in the wake of any surgical operation ; and it was too much taken for granted that removal of the appendages would give relief to their sufferings and restoration to a condition of health and usefulness. And when it was said that "this much they had a right to demand of us, and this we must give them," they were using a very fine phrase meaning nothing more or less than that they were minor deities, and taking for granted their power to restore the patient to health and usefulness, which was sometimes doubtful even to themselves. Each case must be decided on its own merits, and the patient made fully conscious of affairs.

*Conservative operations.*—No doubt the results of conservative operations on the appendages had been disappointing in many cases, but they had been equally gratifying in other cases, and the practical point was to find out in which cases it was well to use conservative methods. It had struck him that the cases where conservative opera-

tion failed were much the same as those in which the removal of the appendages was not followed by clear and full recovery, that is, the uterus and other pelvic structures were implicated, and either radical removal of uterus and adnexa should be performed or the case left to medical treatment. In cases of enlarged cystic ovaries with no adhesions it was not necessary to remove the whole ovary, and the solid fleshy portion might be left. It was a rule with him to remove appendages and not try conservative operation in gonorrhœal cases, but Mr. Taylor had shown that many of these cases had a syphilitic basis, or at least alterative treatment would relieve them. If all women suffering from the group of symptoms given as indicating removal of the uterine appendages were to be so treated they would want much larger hospitals. And this brought him to the mentioning of the curious manner in which one's operations alter with fashion and the want of beds; it seemed as if hysterectomy and vaginal conservative operations had taken the place of many operations for removal of the appendages merely by taking up the beds. The only cases of myoma in which he removed the appendages were the exsanguined, so ably pointed out by Mr. Jordan; the cases of disease of the appendages, and a third group where the myoma involved the whole uterus and was displaceable from the pelvis and the appendages could be removed with great facility and safety. Whenever the appendages were adherent in cases of myoma, it was generally a mistake to remove them, because some portions of ovarian tissue were generally left behind, and the aim of the operation was thus missed since menstruation continued.

Mr. CHARLES RYALL said that the tendency to remove the ovaries had been diminished since it was realised that they had a function of internal secretion which had an effect on the whole system. It was to be remembered that simple cystic disease of the ovary was not a very grave condition, and could be dealt with by conservative methods such as puncture, excision of a wedge of tissue,



&c. He believed that oöphorectomy for myoma should be dropped except in the conditions mentioned by Mr. Furneaux Jordan.

Dr. ARTHUR GILES said that the justifiability of operations of the class grouped together by Dr. Lawrie as Class "A" must largely depend on their results. If a condition incapacitated a woman, and prevented her from earning her living, and an operation would restore her, he thought that Dr. Lawrie was right in saying that the patient had a right to demand relief, and that it was the duty of the surgeon to endeavour to give it her. It had been truly said that some of these operations failed; an important factor, which introduced uncertainty into the results of all kinds of operations, was the neurotic temperament. Many of the patients in Class "A" were no doubt neurotic; and it was well to remember this, since any operation on such a patient was likely to be a failure as regards general symptoms, even if it cured a given local condition. He strongly discountenanced any operation on such patients, except those that were urgently necessary. He pointed out that oöphorectomy had failed to relieve hæmorrhage in cases of myoma, not only owing to a portion of ovary being left behind, but also because the operation had been done in cases where the bleeding was due to a myoma that had become polypoid. In any case where oöphorectomy was contemplated, he thought that the cavity of the uterus ought to be first explored, to eliminate this source of failure. The cases of myoma requiring oöphorectomy were now, in his opinion, very few.

Dr. MACPHERSON LAWRIE, in reply, said that he thought this was probably not the last discussion that they would have on this subject, for it was a burning question. Part of his paper was on questions generally accepted; but on other portions there was evidently still great divergence of opinion. Some of the speakers appeared to assume that he advocated operation in every case of salpingitis; this was

TABLE OF OPERATIONS BY MR. BLAND-SUTTON.

Date	Initials	Age	Disease
1895.			
October 24 ...	J. K....	34	Bilateral chronic salpingitis.
1896.			
February 14 ...	M. S...	18	Leaking pyosalpinx.
April 17 ...	C. P....	25	Double pyosalpinx.
" 20 ...	M. H.	39	Gravid left tube.
" 27 ...	A. F....	27	Right hydrosalpinx.
May 4 ...	E. C....	25	Gravid left tube.
" 21 ...	A. W.	42	Warty sclerosed ovaries.
June 15 ...	L. R....	40	Left pyosalpinx.
July 6 ...	B. B....	17	Tubercular tubes (?)
August 3 ...	F. G....	27	Sclerosed tubes.
" 17 ...	S. C....	24	Gonorrhoeal salpingitis.
October 19 ...	M. C...	45	Left gravid tube.
" 26 ...	A. C....	24	Right inflamed tube and ovary.
November 2 ...	A. E...	37	Inflamed tubes.
1897.			
January 4 ...	H. M.	29	Left pyosalpinx.
" 25 ...	C. D...	32	Left hydrosalpinx.
February 15 ...	E. H...	27	Double hydrosalpinx.
" 15 ...	G. K...	23	Double pyosalpinx.
March 1... ..	M. S...	28	Cystic right ovary.
" 8... ..	F. W...	19	Right tube and ovary. Tubercular.
May 10 ...	M. G...	18	Double oöphorectomy; tubercular tubes.
July 2 ...	A. H...	26	Double gonorrhoeal salpingitis.
" 5 ...	E. B...	33	Sclerosis of both ovaries and tubes.
" 12 ...	E. C....	42	Double pyosalpinx.
August 27 ...	M. S...	34	Double hydrosalpinx.
September 2 ...	C. W.	23	Double tubercular salpingitis.
" 6 ...	E. W.	38	Gravid left tube.
October 4 ...	C. B....	30	Cystic and prolapsed right ovary.
November 22 ...	E. H...	34	Right pyosalpinx.
" 29 ...	A. C....	33	Right hydrosalpinx.
December 6 ...	B. B....	35	Double salpingitis.
1898.			
January 3 ...	L. S....	23	Right gravid tube.
" 3 ...	E. S....	38	Right oöphorectomy and cyst of broad ligament.
" 10 ...	E. M...	45	Right salpingitis and pedunculated fibroid.
" 17 ...	M. ...	...	Left oöphorectomy.
" 31 ...	C. D...	27	Right salpingitis.
February 10 ...	G. H...	25	Right gravid tube.
March 14 ...	M. R...	38	Right sclerosed tube; left tube removed by Lawson Tait.
" 21 ...	O. P....	...	Right gravid tube.
April 4 ...	B. I....	25	Right gravid tube.
May 2 ...	M. W.	40	Huge pyosalpinx, uterine fibroid; hysterectomy also performed.
" 2 ...	E. S....	24	Right gravid tube.

TABLE OF OPERATIONS—*Continued.*

Date	Initials	Age	Disease
1898.			
May 9 ...	S. S....	26	Removal of painful stump after oöphorectomy. The fragment of the ovary was cystic and contained a corpus luteum.
" 9 ...	E. G...	58	Double oöphorectomy; right ovary contained a calcareous ball.
" 30 ...	L. P....	23	Left oöphorectomy for salpingitis.
June 8 ...	E. S....	33	Sclerosed ovary; hysteropexy.
" 13 ...	M. T...	35	Left pyosalpinx and suppurating cyst of left broad ligament.
" 20 ...	H. R...	30	Large bilateral pyosalpinx.
" 13 ...	E. ...	35	Double pyosalpinx.
July 4 ...	K. G...	24	Tubal pregnancy.
" 11 ...	M. A...	39	Oöphorectomy: a pedunculated fibroid was also removed.
" 25 ...	C. ...	...	Left oöphorectomy and hysteropexy.
August 8 ...	J. M....	39	Double salpingitis; double oöphorectomy and hysterectomy was necessary.
September 5 ...	H. W.	27	Double pyosalpinx.
" 19 ...	L. K...	32	Left salpingitis.
October 10 ...	J. D....	25	Right salpingitis.
1899.			
January 16 ...	L. C....	29	Left salpingitis and prolapsed ovary.
" 23 ...	M. P...	26	Cystic right ovary.
February 13 ...	G. F....	32	Double pyosalpinx.
" 13 ...	E. C....	44	Gravid tube.
" 20 ...	M. L...	22	Left pyosalpinx.
" 27 ...	E. C....	29	Bilateral sclerosed tubes.
March 3 ...	S. B....	37	Double oöphorectomy, chronic abscess in each ovary.
" 27 ...	M. H.	21	Double pyosalpinx.
April 24 ...	M. H.	26	Bilateral pyosalpinx.
May 8 ...	M. C....	38	Salpingitis (bilateral).
" 15 ...	E. K...	38	Double pyosalpinx and hysterectomy for septic uterus.
" 15 ...	K. N...	34	Double salpingitis.
" 24 ...	A. G....	40	Right salpingitis and enucleation of a fibroid.
" 29 ...	A. D...	33	Double salpingitis.
" 29 ...	C. G....	28	Huge left pyosalpinx and hysterectomy to stop the bleeding.
June 12 ...	E. C....	45	Bilateral pyosalpinx.
" 12 ...	S. R....	33	Sclerosed tubes.
" 26 ...	A. B....	29	Bilateral tuberculous salpingitis.
November 6 ...	E. P....	23	Left cystic ovary and ventrofixation.
" 20 ...	M. H.	23	Salpingitis and cyst in left ovary.
" 20 ...	M. H.	27	Right salpingitis.
" 27 ...	G. P....	29	Left salpingitis; right ovariectomy.
December 11 ...	E. G...	29	Double tuberculous salpingitis.
1900.			
January 11 ...	M. Z...	32	Left salpingitis.

TABLE OF OPERATIONS—*Continued.*

Date	Initials	Age	Disease
1900.			
February 5 ...	N. E...	30	Bilateral salpingitis.
March 5... ..	L. L...	23	Left salpingitis.
„ 12... ..	F. T....	39	Double pyosalpinx.
„ 19... ..	K. B...	32	Tuberculous salpingitis (bilateral).
April 2... ..	E. N...	29	Sclerosed tubes.
„ 16... ..	E. C....	25	Double pyosalpinx.
„ 16... ..	F. W...	26	Left gravid tube.
„ 23... ..	E. D...	37	Double salpingitis.
„ 30... ..	E. T....	32	Double salpingitis.
May 7 ... ..	P. W...	34	Double salpingitis (tuberculous).
„ 7 ... ..	M. F...	29	Removal of stump left after double oöphor-ectomy: hysterectomy.
„ 14 ... ..	A. D...	30	Huge bilateral hydrosalpinx.
„ 21 ... ..	L. M...	34	Double pyosalpinx.
„ 21 ... ..	D. C...	23	Right hydrosalpinx and left tubo-ovarian abscess.

not the case, it was only in the case of the residue of intractable cases that he advised operation. There were cases that resisted all medical treatment and all milder measures; something had to be done to relieve them; and if an operation would accomplish this he held that it was justified. He had listened with interest to Dr. Routh's remarks; but he could not go so far as Dr. Routh. Dr. Routh had spoken of cases in which he had tried palliative treatment, and they had recovered. In this there was nothing unusual; they had all had such cases. But the question was, What were they to do with the cases that did not recover? He gathered from Mr. Bland Sutton that the cases of tubal disease which required removal were cases of inflammation and of ectopic gestation; and this was precisely the view that he had himself advocated.



*NEW FELLOWS.*

The following gentlemen have been elected Fellows of the Society :—

John Davies, M.B., C.M.Glas.

Maurice V. Dee, M.D., F.R.C.S.Ed.

Thomas Hobbs Crampton, L.K.C.P.I., L.R.C.S.I.

John Hugh Robert Glenn, M.D.Dub., F.R.C.P.I.

Frederic William Kidd, M.D.Dub.

William Augustine Rountree, M.D., M.Ch., R.U.I.

Alexander John Fleming, M.D., M.Ch., R.U.I.

T. Johnston English, M.D.

J. Hutchinson Swanton, M.D., M.A.O., R.U.I.

### THE BUXTON MEETING.

FOR the first time for many years the Council of the Society availed itself of the rule which allows of ordinary meetings being held in places other than London ; and the result of the experiment made this July has been to lead to an unanimous feeling among those who were present that such gatherings might with great pleasure and profit be held more often. Buxton was suggested as a suitable place of meeting on various grounds ; among others, its relatively central position, rendering it easily accessible to Fellows living in the North and the Midlands ; its natural beauty, and its charming surroundings. By the hearty and assiduous co-operation of some of our Local Fellows, of the Buxton Urban District Council, of the Management of the Buxton Gardens, and of the Directors of the Buxton Hydro, the scientific work of the Meeting was supplemented by social gatherings and excursions, in which the lady friends of the Fellows took part. Dr. W. Smyly, Dublin, President of the Society, presided, and amongst those attending were : Mr. E. Stanmore Bishop, Manchester ; Dr. John Blair, Wigan ; Dr. Arthur E. Giles and Mr. Chas. Ryall, London, secretaries ; Dr. H. Macnaughton-Jones, London ; Dr. Heywood Smith, London ; Dr. H. Macnaughton-Jones, jun., London ; Dr. John Hackney, Hythe ; Mr. Gordon Hackney, Hythe ; Dr. Wm. C. Lucy, Hampstead ; Dr. C. H. F. Routh, London ; Dr. Robert Bell, Glasgow ; Dr. W. Armstrong, Buxton ; Dr. C. H. Bennett, London ; Dr. A. E. Hawkes, Liverpool ; Dr. Wm. Walton Don, London ; Dr. E. T. Davies, Liverpool ; Dr. J. R. Watt, Ayr, N.B. ; Dr. Christopher Martin, Birmingham ; Dr. J. W. Draper, Huddersfield ; Dr. Jameson John Macan, Cheam, &c., &c.

The meeting was summoned for Friday morning, July 13. On the previous evening, Dr. and Mrs. William Armstrong entertained the President, Dr. W. J. Smyly and a number of Fellows and friends to dinner; and the gathering was thus unofficially inaugurated in a very pleasant manner. On Friday morning at 10.30, in the Town Hall, Mr. J. E. Harrison, the Vice-chairman of the Buxton Urban District Council, addressing the members of the Society said that, on behalf of the Chairman of the Buxton Urban District Council, who he was sorry could not be present that day, and of the members, he had the honour to welcome the members of this influential Society to Buxton, and also to express their pleasure in granting the members the use of that Town Hall. They did feel it an honour that this being the first time that they had had a meeting in the provinces, they had come to Buxton. He hoped that as they had very favourable weather they would take away a good impression of Buxton and its beautiful surroundings.

The President, in the name of the Society, returned thanks to the Vice-chairman of the Buxton District Council, and to the Council for their kindness in granting them the use of that room. They were very pleased to come to Buxton, and he hoped that this would be a new era in the life of the Society. It was a long time now since they visited the provinces.

After an exhibition of specimens, a paper was read and a discussion opened by Mr. E. Stanmore Bishop, F.R.C.S., of Manchester on "Some Untoward Results Following Abdominal and Pelvic Operations, and the Means requisite to Prevent them." The discussion was taken part in by many of the members, and at its close a visit was made to the Pump Room and Baths, the Natural Bath, the Buxton, Haddon Grove, and Peak Hydros. Luncheon was provided at Mrs. W. Armstrong's, Burlington Road. Subsequently, there was a promenade concert in the Gardens,

under the conductorship of Mr. De Jong. The programme was as follows :—

Quick March	...	...“Liberty Bell”	...	...	Sousa
Overture	...	“Light Cavalry”	...	...	Suppé
Invocation to Battle	...	(“Rienzi”)	...	...	Wagner
Arabian Dance	...	...	...	...	Sarakowski
Operatic Selection	“The Belle of New York”	...	...	...	Kerker
Benediction des Poignards...	(“The Huguenots”)	...	...	...	Meyerbeer
Operatic Selection	...	...“The Mikado”...	...	...	Sullivan

Mrs. Hall provided afternoon tea, and several places of interest were afterwards visited. At eight o'clock the Fellows and lady friends sat down to dinner at the Buxton Hydro, under the Presidency of Dr. W. J. Smyly. Towards the end of the dinner, Dr. C. H. F. Routh took the place of Dr. Smyly, who had to leave for Dublin; and after giving the toast of “The Queen,” proposed the health of those who had been so largely instrumental in promoting the social features of the meeting, especially Dr. and Mrs. Armstrong, Dr. Harburn, Mr. Milligan (Chairman of the Buxton Gardens Committee) and Mr. Lomas (Managing Director of the Buxton Hydro). The evening concluded with a reception and ball, given by the Directors of the Buxton Hydro.

The following day, Saturday, a party of Fellows and friends took part in a delightful excursion to Chatsworth and Haddon Hall. By the courtesy of the Duke of Devonshire, a number of private rooms in Chatsworth were thrown open for inspection, and the beautiful fountains in the grounds were exhibited. The party had the great advantage of being conducted through the splendid mansion by Colonel E. M. Wrench, F.R.C.S., whose long association with Chatsworth rendered him an admirable and delightful guide. The party proceeded to Rowsley for lunch, and then drove to Haddon Hall. On the historic banks of the Wye, where Tourneys were held in a bygone age, professional dignity was laid aside for the time being, while, in waiting their turn to be shown through the Hall,



the party indulged in the ancient game of Rounders. After wandering with the greatest interest through the stately rooms of the old Hall with its priceless tapestries, its picturesque views, and poetic associations, and surveying from the tower the magnificent panorama of the surrounding country, the excursionists returned to Buxton, where not a few remained for another day or two to further explore the beauties of the neighbourhood. The account of the scientific work of the meeting is held over, and will appear in the November number of the Journal.

## ORIGINAL COMMUNICATIONS.

SARCOMA DECIDUO-CELLULARE OR DECIDUOMA  
MALIGNUM.

BY W. J. SMYLY, M.D.

ON July 16, 1888, at a meeting of the Leipsic Obstetrical Society, Professor Säger made a communication upon "two uncommon cases of abortion," one of which was the first recorded example of the disease which we have now to consider. Since then nearly a hundred cases have been recorded, and a considerable literature has accumulated, from which we have learned that this disease differs sufficiently from all others hitherto described to justify its separate consideration. Observers are almost unanimous as to its connection with pregnancy, its clinical features, pathological appearances, and appropriate treatment; and they differ only in their views as to its origin.

The case reported by Säger was so typical of the entire group of recorded cases, that I think a *resumé* of it will serve as an introduction better than any mere definition.

The patient was a young married woman, aged 23, who aborted at the eighth week in consequence of a fall from a railway carriage. The abortion was incomplete and hæmorrhage continued for three weeks. In the fourth week the discharge became fœtid and Säger was called in. He found the patient very anæmic with symptoms of septic absorption and putrefaction of the uterine contents. The uterus was thoroughly cleared out, hæmorrhage and discharge ceased, and the temperature became normal; the pulse however continued to be over 100, and recovery

was so slow that she did not leave her bed for five months. Her protracted convalescence was attributed to a small exudation in the left parametrium; enlargement of the uterus was also observed, but was supposed to be due to subinvolution. She had not long left her bed when she was obliged to return to it again in consequence of fever and pains in the right hypogastrium, where a tumour as large as a goose egg had formed in the neighbourhood of the iliac crest. It was soft and tender, and being supposed to be an abscess was incised but no pus escaped. It consisted of a soft spongy substance of which about a handful was removed, leaving a cavity, at the bottom of which lay the bare and roughened bone. On microscopic examination this tissue showed large multinucleated round cells with spindle cells and numerous apoplexies. Soon after this operation pulmonary symptoms set in with cough and dyspnoea, and she died seven months from the commencement of her illness.

On *post-mortem* examination the uterus was found to be infested with dark purple-red, spongy nodules, varying in size from that of a walnut to that of a large apple. The mucous membrane was smooth and nowhere perforated by the growths. Metastases were found in the iliac fossa, lungs, diaphragm and ribs; the left lung was compressed by a hæmatothorax. Microscopic examination of the uterine tumours showed numerous apoplexies, large nucleated round cells, and cells resembling decidual giant cells, suggesting the idea that here was a new growth of the decidua, belonging to the group sarcomata, which had never before been described.

#### CLINICAL FEATURES.

The clinical features of this disease are thus summed up by Sängér :—

- (1) A birth, abortion, or hydatidiform mole followed by
- (2) Constant or repeated hæmorrhages.
- (3) After this, and generally following an examination or intrauterine manipulation, putrid discharges with fever.

- (4) Increasing size and irregular shape of the uterus.
- (5) Anæmia, rapidly progressing, and towards the close intensely marked.
- (6) Recognisable metastases, especially in the vagina.
- (7) Cough, dyspnœa, bloody expectoration and other symptoms of pulmonary metastases and hæmatothorax.
- (8) Rapid course of the disease which usually proves fatal within six or seven months.

The first point of importance is the connection of this disease with pregnancy. In all recorded cases it has come on after an abortion, or very rarely, after delivery at term ; in about half the cases it has followed the expulsion of a hydatidiform mole, a remarkable fact of much importance with regard to its etiology.

The second important point is hæmorrhage, which either continues after the expulsion of the ovum or commences shortly afterwards. In a few cases it did not occur for a considerable time, and in one, recorded by Whitridge Williams, it was altogether absent, the first evidence of the disease being metastatic deposits in the vagina and lungs. In the majority of cases however it is the most prominent symptom so that the patient soon becomes profoundly anæmic. The surface is pale and in places slightly œdematous, the face especially assumes a pallid icteric cachectic appearance.

When the tumour sloughs the discharge becomes offensive and septic fever sets in. It is therefore of the utmost importance to observe the strictest antiseptic precautions in dealing with these cases.

On physical examination the uterus is found enlarged and often irregular in shape, and in some cases the os is sufficiently dilated to admit a finger by which the growth may then be directly felt.

The course of the disease is one of marked malignancy ; in fact it is the most rapidly fatal of all malignant uterine growths, death occurring from hæmorrhage, septic infection, or pulmonary complications within a few weeks,



very rarely months, after the first symptoms have been observed.

#### PATHOLOGICAL ANATOMY.

The uterus is usually found infested with masses of new growth, varying in size and colour but generally of a dark purple-red. They involve the muscular tissue of the uterus so that the peripheral margin is ill-defined, and the uterine wall after removal appears thinned. The new growth is soft and, where not covered with blood, of a greyish-red hue; it closely resembles placental tissue in its irregularly fissured surface, its fibrous appearance on section, its extreme vascularity and numerous apoplexies, but it is much softer and more friable, and its uterine surface shows a remarkable tendency to slough.

Microscopically these masses are composed of a fibrous reticulum presenting an alveolar and cavernous structure containing numerous apoplexies, two varieties of cellular elements and sometimes chorionic villi, but no glands, blood vessels or lymphatics. The two varieties of cells contrast remarkably. The one are large individual cells varying from round or polygonal to spindle shape, the nuclei are large, and the outline of their cell protoplasm is clearly defined; they resemble Langhans' cells. The others are protoplasmic masses of various shape enclosing a number of irregularly shaped nuclei, rich in chromatin; there is no line of separation between these cells which resemble the syncytial layer forming the superficial covering of the chorionic villi. Both varieties of elements show a marked tendency to retraction of their protoplasm and vacuolation; mitotic figures are frequently observed in the cells but nowhere in the protoplasmic masses.

#### DIAGNOSIS.

As an early diagnosis is of vital importance, we cannot wait for symptoms to develop themselves, fortunately it is not difficult, provided careful clinical and micro-

scopic attention be devoted to it. When hæmorrhage occurs after an abortion or molar pregnancy, the uterus should always be thoroughly evacuated by the finger and curette, so that one can be certain that everything has been removed and a smooth surface left. If after this hæmorrhage recurs, and a second evacuation reveals a quantity of soft friable tissue, the case is certainly not one of simple abortion, but is, in all probability, one of deciduoma; one must, however, be certain that the first curetting was thorough and complete. The size and shape of the uterus varies but is never below the normal, and enlargement of the organ after discharge of the ovum is of much diagnostic value. The os is often sufficiently open to admit the finger, but may require artificial dilatation. Soft masses of friable material resembling placenta are then discovered, and portions removed by the curette should always be submitted to microscopic examination.

#### TREATMENT.

Total extirpation of the uterus is the only method of treatment which has hitherto yielded any benefit, and it is of the utmost importance that this operation should be performed at the earliest possible time, before the patient has become exhausted by hæmorrhage, and before putrefaction has set in, or metastases have occurred. It must not however be regarded as hopeless even under such unfavourable conditions, for cases have been reported by Chrobak and v. Franke where, in spite of evidences of pulmonary embolism as shown by bloody expectoration and other symptoms, recovery has followed operation. Lönnberg-Mannheimer saw numerous metastases in the cervix, introitus vaginæ, and vagina, yet the patient had no return for eighteen months after operation; Cazin found a metastasis in the ovary, yet three years after the operation the patient was well; Schauta extirpated a metastatic growth from the vagina along with the uterus, but at the time of publication there had been no return.

## HISTOGENESIS.

According to most observers this disease is always connected with and is probably due to pregnancy. The only dissentients from this view, at the meeting of the London Obstetrical Society, in the discussion on Dr. Herbert Spencer's case, were Drs. Eden and Kanthack who stated that the microscopic appearances were in no way peculiar but similar to those found in sarcomata in other places, and that in some of the cases pregnancy was doubtful. In the discussion which followed Dr. Haultain's communication to the British Gynæcological Society, however, Dr. Eden stated that he was personally in full agreement with the views of J. Veit, in the *Handbuch der Gynækologie*, that the disease was a sarcoma modified by the occurrence of pregnancy. We may therefore assume, as generally accepted, that the disease is in some way due to pregnancy.

In order to understand the conflicting views as to its origin we must briefly recall the normal condition of the tissues which it affects. The placental villi consist of a stroma covered by two layers of epithelium, an inner, called Langhans' layer, composed of individual cells with a distinct cell wall, and an outer, formed of protoplasmic masses without any line of demarcation, termed the syncytium. These villi penetrate the decidua serotina and maternal blood vessels forming the placenta.

Now the disease which we are considering has been supposed by different observers to originate from each of these structures, and hence the varying nomenclature; thus Säger believes that it originated in the decidua and he gave it at first the name of deciduoma malignum but subsequently he preferred to call it sarcoma deciduo-cellulare because he believed that it originated in the cellular layer of that membrane after it had been altered by pregnancy. Gottschalk believed that in a case described by him, it originated in the stroma of the villi. Marchand, Gebhard, and Haultain attributed its origin to the epithelium covering

the villi and Whitridge Williams to the outer layer or syncytium only, and termed it carcinoma syncytiale, chorion epithelioma, or blastoma-deciduo-chorion-cellulare.

These authorities may therefore be divided into those who hold that the disease is a sarcoma, and those who regard it as a carcinoma. Säger regarded it as a sarcoma of the cellular layer of the decidua because of the similarity of structure in both, the size and shape of the cells, and the presence of a reticulum; the only difference being that in the pathological cells the nuclei were larger and the surrounding protoplasmic ring narrower; he rejected Veit's theory that the disease was due to the modification of a pre-existing sarcoma, because no case had been recorded of the implantation of an ovum upon a sarcomatous or carcinomatous endometrium, and he believed that his claim to the growth being different from all others hitherto described stood or fell with its origin during pregnancy. Veit, however, in the newly published *Handbuch der Gynækologie*, still maintains that the sarcoma precedes the pregnancy and is modified by it. He admits that no case has been recorded of the implantation of an ovum upon a carcinomatous endometrium; but in nodular sarcoma the membrane resembles that in myomatous uteri and that as pregnancy occurs in the one so it may also in the other. He considers that it is impossible to regard all the protoplasmic masses as true syncytium derived from the outer layer of the villi, and that as it has been shown that in normal pregnancy other cells (such as the epithelium of the lining membrane of the uterus and especially of its glands), often take on a syncytial form and that therefore syncytium in the wider sense must be regarded not as a distinct tissue but as a stage in the development of certain cells, so a sarcoma may, under the influence of pregnancy, come to resemble syncytium. Fœtal elements are not always found in these cases and therefore, cannot be regarded as the chief characteristic, but masses resembling syncytium are the rule, and the disease should be regarded as a process in which, under



the influence of pregnancy, certain cells take on a syncytial character. Hydatidiform moles so frequently associated with deciduoma are, not the cause, but the result, of uterine disease, and, regarding deciduoma in a similar manner, the primary disease is to be sought for in the uterus.

In the myomatous uterus the uterine mucous membrane is in a condition resembling that in fibro-sarcomata ; pregnancy often occurs in the former case and may do so in the latter, but, under the influence of pregnancy, the growth undergoes changes and its cells assume a syncytial character, and under the influence of the growth, the pregnancy may be disturbed or ended, develop an hydatidiform mole or may go to term. At the birth the entire ovum may be expelled, or villi, or some villous epithelium may be retained, grow into the veins, be carried into the circulation and cause metastases ; in either case the tumour goes on growing and leads to a fatal termination. The disease remains the same whether it does or does not contain foetal elements, the presence of which is merely accidental. The essential factors are the original uterine disease and the occurrence of pregnancy under the influence of which the syncytial changes in the growth occur.

Gottschalk in 1892 described a case in which the stroma of the villi was changed into a structure formed entirely of large polymorphous cells whose epithelial covering shewed a remarkable proliferation ; he regarded the disease as a sarcoma and believed that it originated in the stroma of the villi. This case was the first in which the disease was diagnosed and the uterus extirpated during the patient's life.

A number of pathologists regard this disease as of epithelial origin and therefore a carcinoma ; foremost amongst these is Marchand whose writings have done much to elucidate its pathology and especially its connection with hydatidiform mole. In an elaborate paper, beautifully illustrated, read before the British Gynæcological Society in June, 1899, Dr. Haultain warmly advocated Marchand's view and stated that the chain of evidence in favour of

this new growth being of epithelial origin had, to his mind, no weak link, the structural appearances, the physiological prototype of the young villi, and the interesting association with myxoma of the chorion, which it closely resembles anatomically, physiologically and pathologically, all serving to prove that it is of epithelial origin.

It would be impossible in the present state of our knowledge to say which of these views is the correct one, but personally, I am inclined to believe that Veit's opinions are the least fanciful and most probably correct.

In the following case the disease was directly associated with an hydatidiform mole and the structure of the new growth essentially characteristic.

Mrs. G., aged 33, the mother of four children, had suffered for some years from retroversion and metritis. The pregnancy which ended so disastrously commenced in February, 1897, and threatened to end in abortion, in April, this was however averted, and the uterus continued to enlarge until August. It then ceased to do so, and I therefore came to the conclusion that the foetus was dead, but as there were no urgent symptoms, and as the patient was averse to operative interference, I awaited its natural expulsion; when a month after full term there was no sign of this taking place, I determined to interfere, and accordingly on December 18, introduced seatangle tents, and the following day, having completed the dilatation with Hegar's dilators, I extracted an hydatidiform mole, emptied the uterus completely and scraped it with Rheinstädter's spoon. She made a good convalescence, but her periods soon returned and were profuse. In March, 1898 when staying with some friends at Monkstown, I was informed that she had severe hæmorrhage, and I advised her to call in a local practitioner but as she did not do so, I concluded that the account I had received was exaggerated. Shortly after this she called upon me at my house, and upon examination I found a swelling in Douglas's pouch, which felt like a retroverted fundus; but upon further examination I found the fundus in its

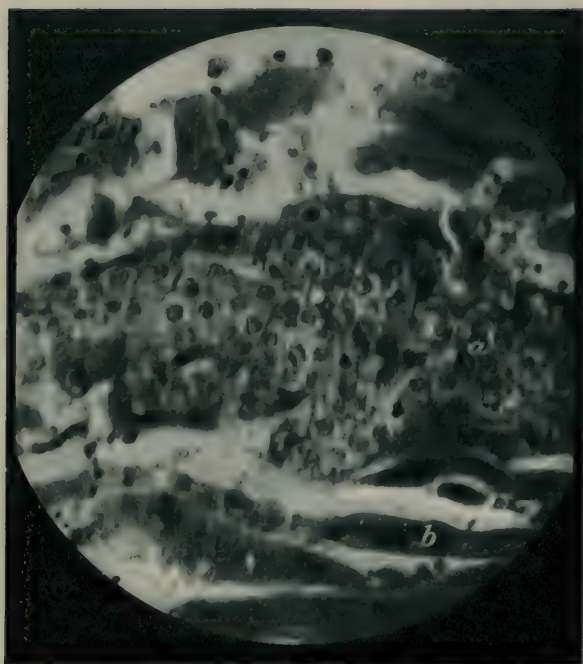
normal position. I then supposed that the tumour at the back was an enlarged tube, and considered it to be a contra-indication to intra-uterine interference. She continued to have hæmorrhages after this, and at ten o'clock p.m., on May 10, her husband called upon me and told me that she had violent pains and hæmorrhage. I at once went out and found her in a condition of intense anæmia; her bed and a night-chair beside it, contained an enormous quantity of blood and clots; she was almost pulseless, cold, and very restless. I immediately washed out her vagina and uterus with very hot creolin lotion and plugged the vagina with iodoform gauze, and cotton wadding moistened with creolin lotion. The Master of the Rotunda Hospital, who had been summoned in the meantime, arrived about midnight, and remained with me about three hours. During this time she had been steadily improving and as no blood came through the plug we agreed to give her half a grain of morphia hypodermically, and postpone further measures until daylight. At six o'clock, however, violent and agonising expulsive pains set in, which were not relieved by a grain of opium administered by the mouth and one third of a grain of morphia hypodermically. The plug soon became saturated with blood and a brisk hæmorrhage came through it. The patient became faint and restless, calling out for air and refusing local interference. Dr. Purefoy was again summoned and also Dr. Piel, and in spite of her alarming condition she was etherised and the plug removed. I now found the os sufficiently dilated to admit two fingers which at once detected and removed a large quantity of placenta-like tissue; the uterus was thoroughly cleared out by Rheinstädter's flushing curette, but the wall was so thin that during the process I was in constant fear of perforating it. Plugging being for this reason out of the question, and the prevention of further hæmorrhage a matter of vital importance, I washed out the cavity with a dilute solution of perchloride of iron. The patient was by this time in a very collapsed condition, her limbs cold, and

brow bathed with clammy sweat. Having used all ordinary means with little apparent benefit, we resolved to infuse saline solution, but by the time the necessary apparatus had been procured she was so far recovered that we considered it unnecessary. During the next few days she improved slowly, but on the third morning the discharge became offensive, and the uterus was washed out with creolin lotion, and as the temperature continued to rise this was repeated daily until the sixth day, when I found the organ completely fixed by parametric inflammation; she complained of intense pelvic pain and vesical irritation. On the tenth day the base of the right lung became solid, with much cough and dyspnoea, an empyema formed on the same side from which a quantity of stinking pus was subsequently evacuated. The septic fever continued for about two months when she died. There was no *post-mortem* examination.

It was only at the time of operation that the possibility of the case being one of deciduoma malignum occurred to us, and the diagnosis was confirmed by Dr. Earl's examination of the tissues removed.

The microscopic appearances are well shown in the accompanying photographs which were taken for me by Professor Scott, from Dr. Earl's preparations. I showed these specimens at the meeting of the British Medical Association in Edinburgh, and Dr. Sanger declared the case to be a typical example of the disease which he had described.





Section from DR. SMYLY'S case of Sarcoma-deciduo-cellulare.

*a* Langhan's Cells.

*b* Syncytium.



## KRAUROSIS OF THE VULVA.

BY P. Z. HEBERT, M.D.

KRAUROSIS, a rare form of disease affecting the external genitals of women, consists in an atrophy of the soft tissues of the vulva, involving the vestibule of the vagina, the labia minora, the prepuce, the clitoris, the labia majora, and sometimes even the perineum, the vaginal wall, or the anus, and rendering those structures liable to fissures and laceration when they are submitted to tension, particularly during labour or coition.

## PATHOLOGY.

The following morbid changes are found in the affected tissues. The horny layer of the epidermis is thickened and infiltrated with leucocytes, and the stratum lucidum, although generally absent in the epidermis of those regions, may be found in places where the horny layer is most hypertrophied; the granular layer (stratum granulosum) is considerably increased in thickness and in the number of its cells; the rete mucosum also presents evidences of hypertrophy and crowds upon the papillæ of the true skin.

In the derma, the papillæ are atrophied, thinned and elongated, and in some places have entirely disappeared. They are also infiltrated with embryonic cells. The connective tissue of this layer has lost its normal undulations and its filaments appear in parallel bands. In the upper surface of the derma, the elastic tissue has entirely disappeared and is considerably diminished in the inferior part. Both the sudoriparous and sebaceous glands have undergone complete atrophy and the nervous and vascular apparatus of the skin are in a state of degeneration.

In the early stage of the affection, the morbid appearances are those of a chronic inflammation of the skin, with marked hypertrophy of all the layers of the epidermis and a destructive process going on in the true skin. At a later period the epidermis exhibits less hypertrophy, but always remains thicker than in its normal condition, and the true skin involving the subcutaneous cellular tissue contracts, the parts affected presenting the appearances of an atrophic and sclerosed condition.

#### SYMPTOMS.

The first observable morbid changes consist of small vascular patches appearing around the orifice of the vagina and depressed below the adjacent epithelial surface. They are very tender to the touch, the pain being sometimes so severe as to preclude the possibility of sexual intercourse. These patches are of a brick red or bright purple colour, and after lasting for some months disappear, to be succeeded by new ones which come out in other places. The vaginal orifice gradually becomes narrowed and loses its elasticity. The disease is sometimes limited to isolated areas, at others it spreads uniformly from a common centre starting either from the vestibule of the vagina extending to the nymphæ, or from the posterior commissure.

In well marked cases, the labia minora may be almost completely absent, and present only a simple transverse fold across the clitoris, and the clitoris itself be concealed behind the fold of skin representing the nymphæ, or retracted out of sight into its sheath. The labia majora in such cases are also atrophied and but slightly elevated above the surrounding structures. The integument is generally dry and in those areas where the atrophy is most marked, its whitish or greyish white colour contrasts with the shining greyish pink of the adjacent parts. The friability of the skin is afterwards betrayed by the presence of fissures or lacerations. The excessive thickness of the epidermis is also obvious in many places.



As a consequence of such atrophy, a concentric shrinking or narrowing of the external genitals takes place, giving the appearance of a diminution in the size of the vulva, and the normal folds of the parts become effaced.

The subjective symptoms comprise a feeling of contraction in the vagina and a sense of tension and weight in the parts. There may be intense pain, which is described as burning or gnawing, especially during micturition; coitus may be unbearable, an uncomfortable feeling is set up by any movement, such as the straining accompanying the act of defæcation, or even walking. In some cases, intolerable pruritus has preceded all the other symptoms and continued persistently; in others the itching has not supervened until after other symptoms had been observed, and in some instances no itching has been experienced at all; indeed no symptom may attract the patient's attention until the friability of the tissues has been discovered during labour, or some other objective symptoms has been observed by the medical attendant at the time of an examination.

#### DIAGNOSIS.

In the advanced stages, when the atrophic changes have taken place, the diagnosis presents little or no difficulty. The contraction of the vulva due to the atrophy of the true skin and subcutaneous tissues, the thickness and roughness of the epidermis, the dry surface, the pearly white colour of the most affected areas, contrasting with that of the adjacent brighter surfaces, the fissures and other evidences of the friability of the skin, and last but not least, the characteristic microscopical appearances of the skin and subcutaneous cellular tissue present a clinical picture not easily mistaken for any other form of disease.

#### PROGNOSIS.

The disease is slow in its progress and of many years' duration. It leads to total suspension of marital intercourse.

It has frequently been accompanied with cancerous deposits in the diseased structures, and the question has arisen whether it has not had some causative influence in promoting the cancer. Lawson Tait was of opinion that the degenerative process worked its own cure and that all cases got well in time though the disease might last for many years; but, subsequent observers have not corroborated that view, and although the disease may assume a more or less quiescent condition, the atrophic and sclerotic changes are too substantial to be undone.

#### ÆTIOLOGY.

Bacteriology has as yet afforded no information of a positive character on the cause of this disease. Probably a greater number of cases occur at about the time of the menopause, but Tait observed the disease in a young girl of 17, and v. Mars, in a woman of 62. Virgins and married women are alike affected. Of twelve cases reported by Breisky, pruritus had existed in four before the manifestation of the disease, only three had suffered from gonorrhœa, in none was there any history of syphilis, none had suffered from eczema or other skin eruption, nor could difficult labours, puerperal inflammation or traumatism be pointed to as possible ætiological factors. There was no sugar in the urine of any of the twelve cases. According to Veit, pruritus and the scratching it involves has much to do with the production of the inflammatory process observed in kraurosis; but it must not be forgotten that the pruritus, in many instances, manifests itself only after the disease has been well established, whilst it is entirely absent in others. It is not improbable that the origin of the malady may be traceable to some form of neuritis resulting in certain trophic disturbances which characterise the morbid process of the disease, but no direct fact can at present be adduced in support of this view except the absence of other palpable causes; perhaps pruritus and masturbation could account for the origin of such neuritis in many cases.

## TREATMENT.

Avoid sexual intercourse and give rest to the parts. Strong carbolic acid applied to the vascular areas gives great relief, but only temporarily; the cautery is also very effectual. The application of glycerine and acetate of lead at night between the nymphæ is beneficial. Cocaine in the hands of Lawson Tait, for the first ten or twelve applications relieved pain like a charm, but afterwards increased it. Powders, such as boric acid, dermatol, &c., may be applied to the vulva with benefit. If there is vaginitis, boric acid or borax douches will convert a pus discharge into a mucoid one, then astringent lotions (such as chloride of zinc gr.  $\frac{1}{4}$  to the ounce or liquor plumbi acetatis, 1 part to 40) are recommended to arrest the discharge. Herman suggests, in suitable cases, the enlargement of the vaginal orifice by operation. Phenazone given internally in doses of 5 to 10 grains three times a day is remarkably effective in alleviating pain and itching in this and other forms of skin affections and its administration may be continued for weeks at a time without producing any harm; as it has many incompatibles it had better be given by itself in the form of tabloids or in a simple solution with some liquid extract of liquorice to disguise its taste. None of this treatment, however, can arrest the course of the disease, and Martin has suggested the excision of the diseased structures, uniting the edges of the wound with catgut by superposed continuous sutures. The results have been most satisfactory; in the great majority of the cases upon which he operated, a radical cure was effected. The operation, of course, is restricted to those cases in which the morbid changes have not extended beyond certain limits.

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A SURGICAL CURIOSITY.—AN OVARIAN CYST REMOVED  
FROM THE ABDOMINAL WALL.

BY SKENE KEITH, M.B., F.R.C.S.Ed.

TEN years ago a lady, aged 36, consulted the late Dr. Thomas Keith on account of a considerable abdominal enlargement, and with a view to its treatment by electricity. The history was a simple one, and consisted in the statement that a somewhat similar growth had appeared five times within the preceding two years. Five times these enlargements had suddenly disappeared. Every time the sudden lessening in size was followed by what appears to have been a sharp attack of peritonitis.

When the abdomen was examined the whole space up to the level of the ribs was found to be filled by a very hard tumour, giving one the impression that it was an uterine fibroid. There was little but the history to prevent one feeling sure that the growth was a solid one, and as a result of ignoring the patient's statement, the tumour had been diagnosed by several to be a fibroid. The patient was told that the growth was an ovarian tumour, and ought to be removed. Operative interference was positively declined as there were six opinions against operation. A short time afterwards, in March, 1890, the tumour ruptured for the sixth time. The patient nearly died of peritonitis, and on her recovery she consented to have the tumour removed. The operation was performed in May of the same year. There were numerous bands and much firm close adhesion in the pelvis; some fluid was present in the peritoneal cavity. Floating in this fluid and attached to the abdominal

contents in all directions were hundreds of soft sticky bodies of the appearance of boiled sago and of the shape of melon seeds. They were removed with great difficulty, by sponging and washing out. The second ovary was enlarged and was removed. No papillomatous growth was seen on the intestine, but in the interior of the tumour there were several papillomatous masses. Microscopic examination of the fluid showed many cells with large nuclei, but no cell was found containing more than one nucleus, and only a few doubtful sprouting masses were discovered. No sections were made of the cyst wall.

The prognosis was not very encouraging, though we did not look on the case as certainly malignant, and hoped that if the patient were well at the end of the first year there might be no return of the disease.

For three and a-half years the patient remained in good health. In October, 1893, she consulted me as her abdomen did not feel quite comfortable. I was not able to detect anything abnormal, but a month later there was a mass in the pelvis closely connected to the right side of the uterus, half as large as my fist, and a smaller one above the pubes on the same side. During the following seven months the patient steadily lost ground, the limbs and chest became thin, and the abdomen grew larger mostly from flatulent distension. There was much indigestion, and almost constant abdominal pain. Two additional masses appeared, one in the left flank and one beneath the lower part of the scar. By June, when the patient went to the country, she had become very feeble, and there was little flesh left on her body. I did not see her again until October. Much to my surprise she had improved, she had put on a considerable amount of weight, and all the swellings except the one beneath the wound had become smaller. Improvement continued all through the winter, until by the beginning of summer the swellings had entirely disappeared, except the central one which was little larger than a walnut. Soon after this the growth began to increase in size, but very very

slowly indeed. At first it gave rise to no inconvenience and the patient continued to improve in health until she was apparently perfectly well. The tumour seemed to be situated immediately beneath the abdominal wall, and gradually increased in size until it extended from a little above the pubes, up to from four to five inches above the umbilicus, its width being somewhere about six inches, and its depth from before backwards being about the same. At one part fluctuation could be detected, but the main mass seemed to be solid. At this stage the diagnosis was limited to saying that the growth was adherent to the abdominal wall, and probably to the intestine, and that the possibility of removal depended on the amount and quality of the intestinal adhesions. I put off the operation as long as possible as I felt sure that if an operation were performed without success, the patient would quickly break down, and because so long as the growth did not increase much in size, and gave rise to little trouble, there was no cause for hurry. At last the skin over the lower part having become inflamed from pressure, I said that we had waited as long as was advisable, and that the operation ought now to be performed. This was done a year ago, and a cyst having all the appearances of an ordinary ovarian tumour was removed from the abdominal wall. My intention was to open into the peritoneal cavity above the upper limit of the growth, to determine the nature of the tumour and whether it could be removed or not. Fortunately while I was doing this I injured what turned out to be the cyst wall, and there was at once a gush of dark brown fluid. Between two and three pints came away altogether. Being now relieved of all fear of hæmorrhage from the tumour itself, the sac was more freely opened, and guided by the fingers in its interior, it was separated from its connection round and round. As the dissection was continued it was seen that the cyst was an unilocular one, and one part was, I might almost say, "dug out" of the abdominal wall on the left side, and another from the right. The former was large enough to



have held half a pint. These two parts were situated in the wall superficial to the abdominal muscles, and their enucleation would have been well nigh hopeless but for the guiding finger inside the cyst. The posterior part of the cyst was adherent to the small intestine. After separating it largely I found that a part, the size of the palm of my hand, was so incorporated with the intestines, that I could not separate the one from the other. The greater part of the cyst wall was therefore cut off and the remainder stitched into the wound, after an attempt to remove the lining—Miner's enucleation—had failed. I closed the remainder of the wound as I always do with stitches passed through the whole thickness of the abdominal wall, stitching in layers, being unnecessary if the edge only of the peritoneum is taken up. Spenser Wells used to say that an hour was long enough for any operation, and he was not far from the truth, even in the days when tumours were larger and operations more complicated than they usually are now; but this operation took nearer two hours than one, for until nearly the end, I did not know what might turn up, and even going so slowly and carefully, I nearly injured the intestine.

The tumour was, I believe, an ovarian one, although it is difficult to explain how it got into the situation in which it was found. By far the greater part lay in the superficial parts of the abdominal wall, and the small intestine was the only abdominal organ to which it was attached. The part of the wound where the cyst wall was included took between six and seven weeks to heal, and there is now a weakness in that situation as when skin and peritoneum are stitched together, or what comes to much the same thing, when a considerable width of peritoneum is drawn up into the wound.

Not long ago I had to see the patient again as there was supposed to be some return of the disease. Through, and attached to the scar, an irregular hard mass was felt, but it pitted slightly on pressure, and it was got rid of by medicine and injections. The swellings described in the early part of

the case were not fæcal accumulations ; they grew slowly, and they went away slowly, and as they went away the general health steadily improved.

The case may be, I think, safely classed as one of the curiosities of surgery.

## REVIEWS.

OPERATIVE AND PRACTICAL SURGERY. For the Use of Students and Practitioners. By THOMAS CARWARDINE, M.S.Lond., F.R.C.S., Assistant Surgeon to the Bristol Royal Infirmary. With Chapters on the Eye, Ear, and Teeth, by Messrs. F. R. Cross, W. H. Harsant and W. R. Ackland; on the Nose and Larynx, by Dr. P. Watson Williams; and on Surgical Bacteriology, by Dr. J. O. Symes. Large 8vo, 650 pp. 10s. 6d. net. With over 500 original illustrations by the Author, and numerous woodcuts. Bristol: John Wright and Co.; London: Simpkin and Co., Ltd., 1900.

This manual is intended to assist the student and practitioner in the appreciation and application of operative and practical surgery, and there is no doubt that Mr. Carwardine has produced a very attractive and useful volume. It is very well got up and freely illustrated with a number of original and clearly executed drawings. These are for the most part original. It is no doubt extremely difficult for any two persons to agree as to what should be included and what excluded from a work of this nature. Mr. Carwardine has placed succinctly before the practitioner most of those points of minor surgery with which he is likely to meet in general practice, and he has touched upon many of the major operations in which such a practitioner may have to perform the *rôle* of assistant.

The chapters on bandaging, dislocations and fractures, are especially graphically illustrated and described, and the Section X., in which he acknowledges the assistance of Mr.

Ackland, Mr. Watson Williams, Mr. Harcourt, and Mr. F. R. Carr, is equally practical and clear.

Some exception might be taken in our opinion to the inclusion, in such a work, of some of the major operations ; it is not possible to give a sufficiently elaborate account of these to make the description of any real use to a practitioner, who would certainly never undertake them. And indeed, if he had such cases in his charge, he would (if he followed Mr. Carwardine's own advice) have recourse in the first place to one of the regular treatises on that particular subject. Perhaps the chapter on the female genital organs exemplifies this as much or more than any other. Hysterectomy (either abdominal or vaginal) cannot be discussed with much advantage, even from an assistant's point of view, in six small pages of large type, and we cannot help thinking that this space might very profitably have been given to elaborating the description of operations for ruptured perinæum, which many a practitioner has to perform. Lawson Tait's flap-splitting method is dismissed in six lines and two illustrations, which in this instance we do not quite agree in considering "self-explanatory."

Stenosis of the cervix, cervical lacerations and uterine prolapse, with their operative procedure, are allowed one page, and the reader is referred to books on diseases of women for further information. If such operations are not considered to be in the scope of such a book by the author (and we quite understand the question being an arguable one), we do not quite comprehend the logic of including an illustration of the insertion of a trocar into an ovarian cyst, with a few lines of description of the operation for ovariectomy.

Beyond therefore feeling that Mr. Carwardine might have left out some of these all too brief descriptions of some of the major operations, and given us in their place more illustrations from his facile pen of minor (but to the practitioner very important) matters, we can recommend his book as extremely readable and instructive.



PRACTICAL GYNÆCOLOGY: A HANDBOOK ON THE DISEASES OF WOMEN. By HEYWOOD SMITH, M.A., M.D.Oxon. Second Edition. Cr. 8vo., cloth, 5s. net. Glaisner : Wigmore Street. 1900.

It was a bold undertaking to re-edit, without completely re-writing, a book whose previous edition dates back twenty-three years; more especially when it treats of a branch of our art that has made such tremendous progress in the meantime as gynæcology has done. In his preface to the present edition the author takes note of this fact and very graciously accords much praise to our Society for the large share it has had in such pioneering. The book, which is quite up to date, such as we would expect from the pen of one who has been all the time an active worker in the front rank, has not been altered in plan. It is certainly not a Student's Handbook, but a *vade mecum* for the busy general practitioner, who will find it a reliable and valuable guide in cases where his small earlier teaching and later only occasional experience, makes some such assistance absolutely necessary. The definitions are for the most part clear and sufficient, the principal symptoms distinctly defined and the treatment that generally accepted. We cannot but express a wish that Dr. Heywood Smith had completely re-written the work; he would then probably have eliminated a few pages (in paragraphs here and there), that too evidently remind us of the teaching of this subject in 1896. The book is admirably fitted for the purpose for which it has been written and deserves a wide circulation.

THE EARLY TREATMENT OF APPENDICITIS ESPECIALLY CONSIDERED FROM A MEDICAL STANDPOINT. By DONALD W. C. HOOD, M.D., F.R.C.P.Lond., Senior Physician West London Hospital. Demy 8vo, 38 pp. London : Bale, Sons and Danielsson, Ltd.

This work is the development of a post-graduate lecture delivered at the West London Hospital some three years

ago. Dr. Hood insists on the importance of early diagnosis and upon its extreme difficulty in some cases. He points out how closely inflammation of the adnexa may simulate appendicitis; of the necessity in women of excluding in the diagnosis such conditions as strangulation (torsion of the pedicle?) of an ovarian cyst; an inflamed or ruptured cyst, and extrauterine gestation or hæmatocele. The author speaks with very strong conviction of the success to be obtained by opium in conjunction with complete rest, abstention from purgatives and a strictly slop diet.

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# THE BRITISH GYNÆCOLOGICAL JOURNAL.

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*BRITISH GYNÆCOLOGICAL SOCIETY.*

FRIDAY, JULY 13, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

THE July meeting of the Society was held at Buxton, where a number of the Fellows of the Society and their lady friends were hospitably entertained. The scientific work of the meeting took place in the Town Hall. Mr. J. E. Harrison, Chairman of the Buxton Urban District Council, delivered an address of welcome to the town, which was acknowledged by the President.

## SPECIMENS.

CASE OF NECROSIS OF CERVIX UTERI FOLLOWING SUB-PERITONEAL HYSTERECTOMY. By CHARLES RYALL, F.R.C.S., Surgeon to the Cancer Hospital; Surgeon to the Gordon Hospital for Fistula; Surgeon to the Out-Patients, London Lock Hospital.

M. A., aged 49, unmarried, was first seen by me in April last, and she was then recovering from an attack of phlebitis in both femoral veins. For two years she had suffered from

pain in the groins and thighs, which had not only become gradually worse, but was continual while walking or standing, so much so that she was afraid to get about much. There was sacral pain, but not of a severe character. She also suffered from morning sickness, obstinate constipation, frequent attacks of retention of urine, and sometimes frequency of micturition. The catamenia still persisted, but had always been irregular and scanty.

On examination, a hard, irregular-shaped tumour could be felt in the pelvis, reaching nearly to the umbilicus, and bimanual examination showed that it was incorporated with the uterus, scarcely movable, and that a large boss of the tumour filled Douglas's pouch.

Multiple fibromyomata were diagnosed, and hysterectomy was recommended because of the pressure symptoms.

*Operation, May 4.*—By a median abdominal incision subperitoneal hysterectomy was performed, and there were numerous adhesions to be dealt with and also considerable difficulty in liberating the uterus from the pelvis and pulling it outside the abdominal wound. The patient suffered so severely from shock that the operation had to be completed in great haste. Some uterine tissue was left on the posterior flap and the cervix was divided some distance above the point of ligation of the uterine arteries. The operation was then completed in the usual way. The patient went on very well for the first few days, but her temperature began to ascend on the fifth day, and on the seventh reached 102° F. There was a profuse dark-coloured, foul-smelling discharge from the vagina, and necrosis of the cervical stump was diagnosed, but examination through a Ferguson's speculum revealed nothing abnormal. On the tenth day a slough was passed *per vaginam*, and this consisted of a disc of cervical tissue  $\frac{1}{4}$  in. thick, with the uterine tissue left in the posterior flap attached. After this she made an uninterrupted recovery. My own custom has been not to leave any uterine tissue in the posterior flap and to sever the cervix practically at the site of ligation of the uterine vessels,



and I believe that in this case the cause of the necrosis was neglecting to follow these steps. Owing to the severe collapse from which the patient was suffering speed was the most important point to consider.

Dr. MACNAUGHTON-JONES said that he also had met with an instance of necrosis in the cervical stump following supra-vaginal hysterectomy undertaken for the removal of a large myoma. The operation presented no unusual features, and the patient at first went on well; but on the fifth day the temperature rose, followed by a vaginal discharge. With douching, the temperature fell after a time; then one night the nurse came round to say that a large mass had been passed in the douche, and on going to see the patient he found that the mass consisted of the stump of the cervix, with six sutures attached. The patient made a good recovery. The possibility of such a contingency raised a question as to the choice of operation when removing the uterus. The explanation of the occurrence might be that suggested by Mr. Ryall, namely, the amputation of the uterus too high up, above the level at which the uterine arteries were tied.

CASE OF RUPTURED CORNUAL PREGNANCY. By CHRISTOPHER MARTIN, F.R.C.S., Birmingham. Surgeon to the Birmingham and Midland Hospital for Women.

The patient was a married woman, aged 33, and previously had had three children, and three or four miscarriages. He was called to see her on May 5, at nearly midnight. The history he had got was to the effect that she had become pregnant about Christmas time. She had nothing to complain of; she believed she was pregnant, and that everything would be all right. Three or four days before he saw her she began to have symptoms of what looked like an abortion. There was bearing-down pain and irregular flooding. Her own medical man was called in, and believed it to be a case of placenta prævia, and

attempted to dilate the cervix. The patient suddenly collapsed, and he thought she was dead. He (Mr. Martin) was called in to see her, and found her extremely collapsed. The abdomen was full of free fluid, and on vaginal examination he could make out that there was an enlarged uterus and a soft mass behind. He opened her abdomen about midnight, and removed the specimen he showed. There was nothing special about the operation; the regular three ligatures were employed, one securing the vessels on the upper side, one on the inner side, and the third below, securing the large veins. He washed out the abdomen, but did not drain. She rallied very slowly; she was for a month in bed, but ultimately she completely recovered. The specimen was undoubtedly, he thought, one of cornual pregnancy. He came upon the gestation sac, and the foetus was still alive inside. It projected from a rent in the thick muscular walls. The round ligament and Fallopian tube entered the mass on the outer side. This position of the ligament was one of the characteristics of cornual pregnancy. The mass was connected with the other half of the uterus by a very thick pedicle; the rest of the uterus was enlarged, which looked as if it was two or three months pregnant. The appendages on the other side appeared normal. The condition was a rare one; thus, in Mr. Tait's series of cases there was not one of cornual pregnancy. The condition differed from tubal pregnancy (*a*) in that the sac was much thicker, and (*b*) in the position of the round ligament. The patient had usually no symptoms until acute rupture took place, and this usually occurred not before the third month but later, as in this case, four and a-half months. When rupture did take place there was very violent hæmorrhage and the patient rapidly succumbed if not attended to. When he first opened the abdomen it appeared as if he had to do with a case of ruptured uterus, and he thought the patient had been subjected to some violence.

EVIL RESULTS FOLLOWING ABDOMINAL AND PELVIC SURGERY AND THE MEASURES REQUISITE TO PREVENT OR COUNTERACT THEM. By E. STANMORE BISHOP, F.R.C.S.Eng. Hon. Surgeon, Ancoats Hospital, Manchester.

Gentlemen,—When I received the request of your Council—which, like that of Royalty, confers upon the favoured recipient a great honour—that I should open a discussion before this Society, my overwhelming first impression was that I had nothing sufficiently worthy of your attention; but a conversation with a physician in this town, Dr. Harburn, suggested to me that it might be a grateful change from the consideration of severe and magnificent operations to which you are, I might say, habituated, and in which many of you may be considered expert, if I were to attempt to-day to direct your attention rather to the perfection of small details in our common work; to the polishing up of these comparatively new departures, if I may be allowed the phrase, instead of dwelling on new and comparatively ostentatious procedures; I may plead justification in doing so, for it has been said that true genius consists in taking pains; that the most successful man is he who is not above looking after the most insignificant detail of his profession; and, indeed, it is often the apparently small detail that makes all the difference between success and failure in any given case.

How frequently, when discussing abdominal operative work with medical practitioners, and especially if advocating any special surgical proceeding, are we met by some such statement as this?—"Well, my patient has several friends, one or two of whom have undergone operation for that very condition. They advise her against it. One told her, only the other day, 'Don't have it done. Look at me! You have periods of good health. I know you suffer between them, but *I* am never quite free from ill-health. I have a large hernia, and have always to wear a big

belt; besides, I am always in some pain. You leave it alone, as long as you are not really in danger of your life, and they tell me these things never actually kill.'” Besides that, she has probably seen some eminent man or other, who has strongly dissuaded her. He has given her a prescription which generally relieves her and enables her to get about again. He has told her either that her tumour is too small to justify operation, and that it will probably never give her any serious trouble, or else that her case is inoperable; that if it were attempted she would almost certainly die; that if she did not, she would always be an invalid; whilst if she were to wait patiently for the change of life, she would find the whole thing disappear.

You will see, of course, that the supposititious case I am referring to is one of uterine fibromyoma. In order to render my remarks plain and concise it is necessary to focus them on a given disease, and this one will perhaps best serve for the purpose. Now, it must be confessed, that to such statements as these it is very difficult to reply. There is in them so much that is true—or, rather, that has been true—because in the immediate past so many new operations have been brought forward that it is perhaps too early to expect that measures should have been taken to render these evil results impossible—that with concrete examples before her eyes it seems madness for the patient to run the risk of experiencing them in her own person; whilst the statements which are erroneous are so welcome, that she is naturally predisposed to believe them. The evil results of such advice, however, are painfully apparent to those of us who have made a thorough study of the subject. We know that every succeeding month renders possible fresh and preventable complications, new and avoidable risks to the patient's life if left alone, fresh, preventable and immensely more dangerous risks if operation is at last undertaken. We know that if at last, driven by unbearable pain, profuse losses of blood, offensive discharges, œdema of the legs, breathlessness, unwieldy size and the hope



of the long looked for menopause persistently deferred, she turns to operation as her only means of relief, that then, with an immense tumour, many dense and intimate adhesions, possibly double pyosalpinx, a weakened, fatty heart, and hydronephrosis—some or all of these—the great probability is that she will *not* survive, or if, by great good fortune she does, fresh adhesions of intestines will probably form, with all their miseries, the long distended kidneys cannot be expected to return to their normal condition, the cardiac trouble will remain, and she is certain, though relieved of the mere weight of the tumour, to pass the rest of her maimed life, *maimed by delay, not by operation*—in a condition of chronic invalidism. But with the usual logic of the patient's mind, and that of her friends, the result will be credited to the operation, and to that alone.

Is it not, therefore, of immense importance that when we do have the opportunity of removing these tumours whilst yet these secondary changes have not taken place, that our attention should be directed, not merely to the avoidance of death, but, I would almost say, even more to the prevention of evil results which are avoidable by attention to small points in technique, but which if allowed to occur, act as so many obstacles in the way of future operative work in other cases? The effects of one operation are not seen alone in the patient operated upon, they react upon all similar cases to whom directly, or more often indirectly, she is known.

Things tend to move, I conceive, in a vicious circle. Bad results follow delay. Delay is produced by knowledge of former bad results. If you analyse any list of deaths from operation for uterine fibromyomata; if you look up the histories of any of the museum specimens to be found in any large city, you cannot fail to be struck by the fact that the fatal factors in all are not the inevitable and inherent conditions of the tumour; not the constitution of the patient; not even the particular method of operation employed, though as I shall try to show, this has something

to do with it ; but in every case, something imported into the case by delay, something unnecessary, something which requires a certain amount of time to bring about ; that anything like safe work, work which will leave a perfect result behind needs to be done before these factors make their appearance ; and that good results afterwards are due very greatly indeed to the early period in the course of the case at which the operation was performed.

Only within the last month I have had a very instructive case illustrating the evils of delay. Mrs. S., aged 55, has known of the existence of a tumour, associated with uterine hæmorrhage, for eighteen years. She has consulted various medical men, including Sir Spencer Wells, all, with one exception, advising her to wait for the menopause. When I saw her she was very anæmic, losing blood and very offensive discharge in great quantity, and with a large hard tumour, which I show. Part of this was calcified, whilst one intramural growth had become partially extruded from the wall into the uterine canal. The lower end of this had been constricted by the internal os, and the part below was necrotic. The operation, pan-hysterectomy, was very well borne, and all went admirably until seven days after, when she felt faint, and the temperature rose. On the eleventh day the rectum was found packed by hard, extremely offensive stool, which required manual removal. The bowels had acted freely from the first, and she has always claimed that they had always done so during the whole time the tumour had been noted. From the time when these fæcal lumps began to move she became ill, her temperature was irregular, and a large abscess formed in the peritoneum and above the bladder, being walled off from the general cavity by adherent intestine. The pus was evacuated, but the adhesions remained, and much trouble and pain resulted from them, though they have at last, I am glad to say, apparently disappeared. I believe the whole trouble was due to infection from fæces retained in the sacculated colon, which for years had been unable

thoroughly to empty itself. I believe this, because at the time the vaginal and abdominal wounds were soundly healed already by first intention, showing, I think, that infective material had not been introduced at the time of operation.

If, then, we are to get perfect results, we must be able to induce our patients to submit early; we must be able to convince their immediate medical advisers, upon whose counsel their action mainly depends, of the advisability of early recourse to operation. In order to bring this about, everything possible must be done to eliminate the evil results which tend to discredit the work done.

Lockwood, I believe, once divided operations into those which were dangerous to the patient, and those which were dangerous to the operator. I would add a third class which would include the cases of which I have been speaking, viz., those which are dangerous to the reputation of the operation itself.

What, then, are the evil results to which we refer? First, of course, is the mortality, the immediate result. Second, the final results—ventral hernia, sinus, vaginal prolapse, intestinal adhesion or later obstruction, persistent pain and prolonged invalidism.

The mortality has been immensely reduced since the days of Goodell, Spencer Wells, and Knowsley Thornton. The former, speaking of this subject says (1880), "In some otherwise hopeless cases, the womb, together with its appendages, have been removed, but the mortality has been frightful," and, quotes Keith as saying, "The uterus has been pretty frequently removed in Scotland, but all the cases proved fatal with the exception of my solitary three." Spencer Wells (1882) gives a table of 39 cases of removal of uterine tumours with 20 deaths, a mortality of 51·2 per cent., and Keith<sup>1</sup> in 1883, referring to Knowsley Thornton's results at that time, says that one out of every three died.

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<sup>1</sup> *British Medical Journal*, 1883, vol. ii., p. 116.

Contrast these statements with the lists published by

Schauta 148 cases with 5 deaths.

Jacobs 79 " 3 "

Van Ott 189 " 3 "

or our own Christopher Martin's list of 35, mentioned at the March meeting of this Society, with only one death : a total of 449 cases with 12 deaths, or a mortality of 2·6 per cent. To what is this great diminution in mortality due ? At the same meeting, you, Sir, made two statements with which I cordially agree, and which seem to me to epigrammatically express the whole truth. You said that the mortality of operations depended not only on the dexterity of the surgeon, but also on his views of the question ; and secondly, that the mortality had fallen in proportion as more and more of the cervix had been removed. You limited your first statement somewhat, but I think that I should not be going beyond what can be proved, if I extend its application. If a surgeon believes that the majority of cases will disappear at the menopause ; if he thinks the dangers of unoperated fibromyoma exaggerated or imaginary ; if he estimates the evil results sometimes seen after operation as unavoidable ; if he believes it to be "criminal" to interfere surgically except as a last resort, and until the patient has been through a long course of medicine, treatment by baths, electricity, visits to Kreuznach, Woodhall Spa, and other mineral springs ; his mortality is certain to be high, and his results deplorable. If, on the other hand, he sees in any case which consults him, a patient who would not have come to him unless her fibroid was beginning to show symptoms of its presence ; if he carefully notes its position, size, and rate of growth ; if he finds the first dangerous from its proximity to the ureters, or from its developing into the broad ligament, or from its tendency to become submucous, and so produce exhausting hæmorrhages ; if he finds the rate of growth clearly and obviously increasing after a month or two's watching ; if having a clear idea in his own mind of the natural history of these tumours, he



can look forward and forecast the probable condition in six or twelve months—if he sees definite reason to fear pyosalpinx, pressure on ureters, great losses of blood, development into broad ligament or the possibility of necrosis ; if he has the courage of his opinions and determines to forestall these things and operate whilst yet the tumour is uncomplicated by them, his mortality will be low, and his results, if he takes certain precautions, I believe, all that could be wished. As I said at the last meeting at which this question was raised, we may put on one side those slight cases discovered by accident, and in which no important symptoms are present, because we are all I presume, agreed as to leaving these alone.

And your second statement is certainly capable of proof. Panhysterectomy is a term which, like all terms, tends to become identified with a certain proceeding only ; in this case with the operation undertaken from the abdominal side. But it must not be forgotten that all vaginal hysterectomies are, from the nature of things, also panhysterectomies. It is impossible, I conceive, to do a vaginal hysterectomy without at the same time removing the cervix. At all events, I can find, after careful search, no instance of its having ever been done, or even attempted. It would be better, I think, for our purpose to divide these operations into partial hysterectomy performed from above, in which the cervix is left, and total hysterectomy, performed either by the abdominal, the vaginal or by the combined method.

Now if the present mortality of vaginal and panhysterectomy combined are contrasted with that of partial hysterectomy, the advantage of the former as to mortality alone is seen to be very marked, thus—

Second estimated the mortality of hysterectomy with internal treatment of the stump at 50 per cent. Leopold the mortality of supravaginal hysterectomy, with internal or external treatment, at about 21 per cent. Contrast this with Doyen's method of abdominal hysterectomy and mortality of 2·6 per cent. But perhaps we shall get a nearer

approximation to present possibilities if we take the results of a number of operators, some of whom Dr. Cullingworth, Mr. Christopher Martin, and Mrs. Scharlieb, have sent me some as yet unpublished statistics.

Here are two lists: I have placed the results of pan-hysterectomies and vaginal hysterectomies together, as those of total hysterectomy. In the other, the results of all operations, which remove only the body of the uterus, leaving the cervix, as in Baer's, Le Bec's, Kelly's, or Schroeder's operations, as those of partial hysterectomy; and I have avoided those of partial hysterectomy with external treatment of the stump, as being obsolete, and with far too high a mortality.

#### TOTAL HYSTERECTOMY.

Cases. Deaths.				Cases. Deaths.			
Chris. Martin	...	45	1	Van Ott	...	187	3
Mrs. Scharlieb	...	5	0	Chrobak	...	120	5
A. Martin	...	81	6	Leopold	...	74	2
Sänger	...	45	3	Schauta, list of	...	148	5
Rosthorn	...	116	1				

#### PARTIAL HYSTERECTOMY.

Cases. Deaths.				Cases. Deaths.			
Cullingworth	...	72	21	Treub	...	57	5
Mrs. Scharlieb	...	40	4	Jacob	...	9	1
Kelly	...	100	2	W. Duncan	...	68	4

If these are added together, we obtain a mortality for partial hysterectomy of 10·7 per cent., whilst that of complete hysterectomy is only 3·1 per cent.

I am aware that Dr. Champneys has lately given 17 per cent. as the mortality, based upon the records of some of the London hospitals. Is it permissible to think that this should be rather a cause for a "divine discontent" on the part of the operators concerned than a serious attempt to fix the record, after the figures given by Continental and other gynæcologists?

So that the connection suggested by you between decreased mortality and removal of the cervix would seem to be amply justified. The two cases already narrated to-day

by other Fellows admirably emphasise this point, viz., the advisability of the removal of the cervix.

There is one point more before leaving the question of mortality to which, perhaps, attention may be drawn with advantage. One of the main causes of fatality after hysterectomy is peritonitis, or the septic poisoning which peritonitis is Nature's attempt to limit and isolate; and we are all, I presume, agreed in welcoming an action of the bowels, or, at least, passage of flatus, as soon as possible after the operation with a view to the prevention of this. Are we all agreed as to the reason for our practice? I ask this question because a well-known metropolitan operator, in discussing after-treatment, informs me that he does not attempt purgation until sixty hours have elapsed. It is very evident that his reasons for giving an aperient or an enema must be very different to those which influence many of us. If you will permit me, I will briefly state the question as it appears to me, and we shall then see what differences of opinion exist.

The bowels should be well cleared out previously. I presume all agree as to the advisability of this. After the operation, some operators give no food for forty-eight hours, some for twenty-four, and those who do give nourishment by the mouth lay stress upon its being such as is easily absorbed, leaving little or no residue. Clearly then, I take it, if we prescribe a purgative, we do not do it in order to get rid of any fæcal contents, or, at all events, this is not our primary object. The bowels are empty. Often, if preliminary purgation has been well carried out, they will be found collapsed in their entire course at the time of operation. Now, it would appear obvious, that if our sole reason for after-purgation is to prevent re-accumulation of fæces, we are justified in waiting until they again *contain* fæces, or for some sixty hours, as my professional friend does. But is that our reason? Does it indeed enter into the question at all?

Muscattello injected into the peritoneum of dogs, carmine

in a state of suspension. On microscopic examination of the precipitate deposited on the peritoneal surfaces, shortly after the injection of the carmine granules, he, as well as other observers, who have confirmed his observations, found wandering cells interspersed among them, some slightly laden with one or two granules, others greatly distended by the foreign bodies. In addition, there were others which had not as yet taken up their burden; occasionally he saw a granule too large to be surrounded by one leucocyte, and a number apparently joining their forces to encircle the invader. The leucocytes were found in greatest number beneath the omentum. From the peritoneal cavity he traced these cells, with their contained granules, through the intercellular spaces into the lymph spaces, thence into the lymph channels, and finally into the blood. While many empty leucocytes were found in the vicinity of the granules, when they reached the thoracic lymph vessels they always contained the foreign bodies. He proved that there existed a current towards the diaphragm, which inevitably carried the leucocytes and granules upwards into the intrathoracic lymphatics; the granules appeared in the general system of lymphatic glands in the following order. In twenty minutes in the thoracic lymph glands, in ninety minutes in the glands at the hilum of the liver, in one hundred and twenty minutes in the spleen. When the assisting action of gravity was obtained, by suspending the animal with its head down, granules were found in the retrosternal glands within five to seven minutes. When in the opposite position, with the head up, after five and a-half hours granules were not visible to the naked eye in any of the glands, but were found microscopically in the diaphragm, the retrosternal lymph glands, and the intrathoracic glands, but not in the glands of the spleen, the hilum of the liver, pancreas, lumbar, or aortic glands. Von Recklinghausen, whilst he disagreed with Muscatello as to the mechanism of the passage of the granules through the peritoneum, endorsed the fact that they found their way towards the diaphragm.



Two conclusions appear justified by these experiments. First, that foreign materials are removed from the peritoneal cavity by currents which carry them towards the diaphragm, and secondly, that the action of gravity greatly assists and quickens this process.

What are the causes of these peritoneal currents? Two appear to stand out most prominently. First, the pumping action of the diaphragm; and second, the vermicular action of the intestine. With regard to the former, the increase in rapidity of the respiratory movements when peritonitis is impending, suggests that Nature is in this way doing her utmost to quicken the protective absorption. Our power of assistance in this direction is very limited; but it is quite otherwise with reference to the second force, that of vermicular action. This is very greatly under our own control, and what we know of the rapidity of development of micro-organisms under favourable conditions, all of which are present in the abdominal cavity, justifies us, I conceive, in exciting this motive force at the earliest possible moment. Time will not permit me to go into all the physiological and pathological evidence available to support this view. I can only venture in a few moments to give some clinical facts in its favour.

If this is admitted, two practical results necessarily follow in treatment. First, after laparotomy, the small intestine should be excited to act at once, *not in order to empty itself*, but because we wish to produce and maintain intraperitoneal currents which shall carry all stray micro-organisms rapidly away from points where they may develop, into the lymphatics and glands where they will be overpowered and eaten up by their natural enemies, the phagocytes. An additional reason for speed is found in the consideration that micro-organisms allowed to remain quiescent produce toxins which may paralyse the gut and nullify later endeavours to excite its action.

The second result is that after laparotomy, the foot of the bed should be raised as far as practicable. This has

other good effects, but primarily, it answers the purpose of enlisting the action of gravity.

Do actual facts supply any reasons for belief in this theory and do they endorse this practice or not? I think they do unmistakably, and I invite your consideration of the following :—

My metropolitan friend, of whom I spoke just now, with an experience of seventy hysterectomies for fibroid, and who waits sixty hours before commencing purgation, has noted an unusually heavy percentage of cases of death from "intestinal paralysis," a percentage which he describes in a letter to me as "ghastly," and for which he is, more or less, unable to account.

On the other hand, here are three cases in all of which peculiar reasons for sequent peritonitis existed; all of which were treated by early post-operative purgation, with raising of the foot of the bed, and all of which recovered without any sign of peritonitis. The first is a case which I mentioned before this Society in March last, and of which I showed the specimen. It was that of a woman of 64 with a sloughing fibroma, which tore during removal, and the contents produced such an effect upon the raw surfaces they touched, that for the first week a black slough extended from the vaginal to the abdominal wound, and spread along the subcutaneous tissue as far as the abdominal wound extended. Yet there were no symptoms of peritonitis from first to last.

Another is a case of large pyosalpinx in a woman of 28. The temperature at the time of operation was 103°, and the patient was extremely ill. The fimbriated extremity of the tube was plugged by omentum, which tore away during removal, and some of the contents spurted out. The main amount was caught by sponges, but it was impossible to be sure that none escaped and came into contact with the peritoneum. Some must have fouled the deeper connective tissue, and was so virulent that a month later a subdiaphragmatic abscess formed above the liver. This was evacuated,

and the patient perfectly recovered. There was no peritonitis or intestinal paralysis from first to last.

The third is a case of ovarian cyst with twisted pedicle in a woman of 29; firmly adherent to omentum, rectum and posterior peritoneum, from all of which it had to be peeled out, leaving a large oozing raw surface. The abdomen was closed, without drainage, and an abscess followed in the *cavum Retzii*, which greatly delayed her convalescence; yet there never were any signs of intraperitoneal inflammation or intestinal obstruction from adhesion of intestine to the inviting raw surfaces left behind.

Turning from the question of mortality, we must consider the later results of these operations.

Patients who are dead tend to be forgotten, except by their immediate relatives, and by compilers of statistics. It is far otherwise with those who recover from the immediate consequences of operation, but who never perfectly regain their health. These cases constantly remind us of their existence; they, above all others, act strongly in dissuading other sufferers from resort to operation at the most advisable time, *i.e.*, before they are forced to the only effective remedy by painful and dangerous complications.

And many, if not all, of these evil results are, I believe, avoidable.

*Ventral hernia* naturally stands out as one of the most striking. And ventral hernia is a very real danger. Lusk says that in Jacob's clinic there had been hernia in 38 out of 257 patients operated upon, or a percentage of 14.7 per cent. Dr. May Thorne, in a paper on "After Effects of Abdominal Section," has collected 39 cases of ventral hernia occurring after laparotomy, and in 26 cases has given the time at which the hernia first appeared. Seven of these occurred during the first year, 18 under five years. Six cases, however, occurred after seven years, 2 of these fourteen years after the original abdominal section. Five cases were noted by Stone in the Vanderbilt clinic from four months to two years after abdominal section. Alban Doran estimates the frequency of

ventral hernia after abdominal section as high as 1 in 3, though I believe this is far too sweeping an assertion.

Ventral hernia is, of course, due to some weak spot in the abdominal wall, produced by a fault in the method of union after coeliotomy, which spot either yields as soon as the patient assumes the erect position, and the weight of the abdominal contents comes to bear upon it, or later is demonstrated when some severe and sudden or more gentle but continuous increase occurs in the intra-abdominal pressure. Now methods of union naturally divide themselves into two main classes—through and through suturing and the tier suture. All the rest will be seen to be only varieties and modifications of these two. Discussions on the relative value of these two methods are extremely interesting. Many and varied opinions have been expressed, and they and the reasons given for them may be examined, I think, with profit.

In a former discussion one speaker said that his choice of methods for reunion of the abdominal wall would depend upon its thickness. Given a well-developed thick wall he would use through and through suturing; with a very thin wall, which required additional strength, he would suture by tier or triple method. Another expressed his preference for through and through suturing, as saving time; a third also used the same method, but laid stress upon the way in which the sutures were to be passed; they were to be so placed that they took up a wider extent of the fascia, so that, when drawn tight, the deep fascia of one side would either overlap or face, to some extent, that of the opposite side. At a meeting of another Society, one speaker said that there would always be some cases in which hernia was unavoidable. He had seen cases in which the recti muscles were widely separated normally; in such a case no amount of suturing would bring these muscles together.

It is worth while to consider more closely the premises upon which these opinions are founded. If you examine them you will find that the first is based upon an assumption



that all parts of the abdominal wall are of equal value in preventing hernia—that a thick wall, by virtue of its mere thickness, is more capable than a thin one of restraining bulging of its contents. Such an idea merely needs clear statement to demonstrate its falsity. No one would suggest that sub-peritoneal or subcutaneous fat is of any value whatever for this purpose, and yet Carstens advises careful suture of both layers. Everyone will admit that skin and peritoneum are capable of being very easily stretched.

The next idea—that of saving time—need not detain us. Of course, if time is of paramount importance, we are simply abandoning the question of prevention of hernia in favour of the immediate safety of the patient.

The third requires more consideration. It may be taken along with the fourth; and both, I venture to think, show that their upholders have not quite grasped the essentials of the problem with which they are dealing.

The one and *only* structure, the complete and perfect union of which renders post-operative ventral hernia impossible, is the deep fascia overlying or enclosing, according to the height at which it is divided, the rectus muscles. The rectus muscles themselves have nothing to do with it. The term rectus fascia is, in this connection, simply misleading. That the fascia splits to enclose these muscles is purely an incident, and distracts the mind from the true conception of this fascia as being, what it is in very truth, the mutual tendon of the transversalis, external and internal oblique muscles of either side. These muscles acting from either side will, in contracting when their tendon is intact, draw all inside it, nearer to the spinal column. When it is divided they will draw each half of the wall towards their respective sides. That they act upon it at various angles does not detract from this. Their combined action only exemplifies the well-known physical law of the parallelogram of forces. Any suture, therefore, uniting this tendon, and *any other tissue whatever*, will cut through that other tissue, and the suture become loose, *not* because it is too tightly

tied, but because it is being continually pulled upon by the muscles of both sides, which keep it in perpetual tension. Until this other tissue is cut through, the muscles will tend steadily to pull upon it, until at last only the tendon holds, by which time there will be a more or less perceptible gap between its two ends at this point, and this will be filled by scar tissue, granulation tissue, which in its early stage is about the most yielding of all structures. Thus, the foundation of a hernia is laid, and will become apparent when the patient rises once more to an erect position and the weight of the contained organs comes to bear upon any gap; or if not then, it will be seen, sooner or later, when any marked increase in intra-abdominal tension is produced by cough or straining in micturition or defæcation. An examination of Braune's transverse section of the anterior abdominal wall will easily demonstrate this point. The rectus muscles, as I have said, have nothing to do with it. Their strength, their tension, lies in a vertical direction; they have no power to withstand the persistent lateral pull. Sutures bringing their fibres together are useless, since the actual muscular fibres will never unite side to side, and the connective tissue between them is not sufficiently resistant to prevent their being separated by any intra-abdominal viscus, which is able to insinuate itself between them. The normal approximation or separation of the two recti muscles has then no influence whatever upon the occurrence or prevention of ventral hernia. For this purpose union of peritoneum is of no moment, union of skin matters nothing. Union of sub-peritoneal or subcutaneous fat is obviously of no account, approximation of laterally placed muscular fibre does not affect the issue—the only tissue left is the deep fascia—this, and *only* this, stands as an impermeable barrier so long as it is intact. It must, however, be firmly united by sutures, which will not yield or *become loose* until the connection between them has become firm and hard—therefore for at least six weeks—and these sutures must therefore pass only through the fascia itself, and no other tissue what-

ever. All the other tissues are united for totally different reasons—the peritoneum in order to reproduce the closed peritoneal sac, so as to permit once more the play of the normal peritoneal currents, which carry all deleterious materials rapidly into the diaphragmatic lymphatic spaces ; in order, also, to prevent adhesion between the intra-abdominal viscera and the raw edges or surfaces of connective tissue which would otherwise be exposed to them ; in order to prevent entrance of fluids, disintegrating fat droplets, or other matter from the abdominal wound itself. The skin is united for æsthetic purposes, for prevention of the entrance of septic materials into the abdominal wound, for the prevention of pain, for rapid union and formation of a fine scar, &c., neither of them as a prevention against hernia.

If *this* fact is clearly apprehended, it would appear demonstrable that the tier suture is the only scientific method of suture possible, if we wish to prevent the development of ventral hernia, and that the relative thickness or thinness of the abdominal wall, and the approximation or otherwise of the recti muscles have nothing whatever to do with the question.

But if we unite only the peritoneum *per se*, the deep fascia *per se*, and the skin, shall we not leave dead spaces between in which air, fluids, &c., may remain and decompose ? Clearly, unless we obtain some other help than that of our sutures alone to force the intervening tissues together. Such a force, I conceive, is to be found in atmospheric pressure. Before absolutely closing the peritoneum, the patient is lowered from the Trendelenburg to the dorsal position, the intestines once more fill the abdominal cavity, and thus a firm elastic backing is procured for the future steps. In closing the fascia, when the last sutures are introduced, and before they are tied, firm pressure is made over the line of suture, forcing out air and any remaining fluid. The last suture is tied and this layer hermetically closed before the pressure is removed. So with the skin. Sutures

in both are closely applied, and all air pressed out before the last opening is shut. As this last pressure, *i.e.*, that upon the skin, is being removed gradually from above down, celloidin is poured over the line of union. This is not done hurriedly. Each segment of the wound is hermetically sealed before the next segment is uncovered, until the whole surface, including the points of entrance and exit of the sutures, is completely covered with a tightly adherent film of glass-like material, through which the line of union can be seen. As it sets, it contracts with considerable force, and if the application has been satisfactory the area of the wound lies apparently slightly beneath the level of the surrounding parts. In this way, all the tissues are forced together by the external atmospheric pressure, aided by the sutures, and the super-jacent celloidin. No dead spaces can exist, subcutaneous and sub-peritoneal fat are approximated by a force which acts far more powerfully and evenly than any sutures could do, whilst these lowly nourished structures have not their feeble vitality threatened by any compressing or strangulating threads.

There are other advantages obtained by this method, first suggested, I believe, by my colleague, Dr. Williamson, of Manchester. The wound being perfectly covered and protected by this glass-like film which adheres so strongly to every part, requires no dressings. Dressings, I take it, are employed as a protection, and for absorption of fluids issuing from the wound. There is no need for further protection, and no fluids can escape. Why should we wish for their escape? If our wound is aseptic, if our hæmorrhage is perfect, the only fluids which can be present are useful for the more rapid healing of the wound. Only lymph, more or less diluted by serum, can be present—excellent culture material for micro-organisms doubtless, but if no micro-organisms are present, then equally valuable material for the production of rapid union. The more watery portions are easily absorbed, the fibrinous portion remaining as a scaffolding on which to build the new tissue.



And if dressings are unnecessary, the binders which keep those dressings in place become superfluous, and the patient is freed from the annoyance of coverings which tend to ruck up behind the back, and are hot and uncomfortable. As the dressing cannot shift its position, whatever the patient may do, and as we trust to our suturing of the tendon to keep the outlying muscles from tearing it open, not to binders which can exert no satisfactory counter force to their contraction, we need not restrict our patient's movements as we must if we trust for protection to unattached coverings. She can at once lie in any position which is most comfortable, and we are perfectly secure that no deleterious dust or other material can enter the wound. The material itself becomes loose and begins to peel off from the skin in from ten to fourteen or more days, by which time the wound is healed. I have, however, found that in some cases in which a large tumour has been removed the patient welcomes the firm feeling produced by a well-fitting binder, but it must be clearly understood that this is only used for comfort, *not* to prevent muscular contraction.

But for success in the use of this method three things are imperative, first, absolute asepsis; second, absolute hæmostasis; third, absolute expression of air and fluids; all of which conditions are somewhat difficult to obtain, but are possible, and if obtained enable us, I believe, to reap quicker, safer, and more satisfactory results than can be gained in any other way. I am glad to be able to show photos of different cases treated by this method at various dates after operation. The first, as you see, is taken forty-eight hours after operation. The sutures are seen through the transparent dressing, and the puckering normally produced. This puckering of the skin is not due to tension sutures, but simply to the contraction of the material employed. The second is taken from another case seventeen days after operation. The sutures are still in position. They, as well as the condition of the wound,

can easily be seen through the glass-like film which still covers them. The third is from the same case as the first, but three weeks later. The celloidin and the sutures are gone. The area is slightly stained. On the patient's right are the marks of plaster strips, which held a blister in position. The fourth shows a case two and a-half months after operation. You will note that the patient has become stout, and had a tendency towards enteroptosis, but the line of union is retracted below the general level, and is, if anything, the strongest part of the abdominal wall. The fifth is from another case, eight months after operation, and shows how small a scar is left. Indeed, this is rather wider than the usual result. The last is taken twelve months after operation, and shows but very little mark at all.

*Persistent pain following operation and intestinal or omental adhesions* are usually correlated, and anything which tends to decrease the chances of the occurrence of the latter will usually prevent the former. Later intestinal obstruction is also manifestly due to these adhesions. Treves, in his "Intestinal Obstruction," p. 85, says, "The gut at the adherent spot becomes a more or less inert segment in an active tube." "The adherent bowel may offer a more or less definite mechanical obstacle to the passage of its contents." "A part of the colon may present so sharp and rigid a bend as to give to the involved intestines the properties of a stricture." "The abdominal pain is paroxysmal. There is a dragging pain about the parts to which the gut is adherent."

Thus the questions of post-operative pain and early or late intestinal obstruction depend mainly upon the occurrence or prevention of adhesions. The late Greig Smith showed that if we wished to produce extremely firm union, the best way to obtain it was to unite a peritoneal surface to that of raw connective tissue. Conversely, the one thing to be most sedulously avoided, if we wish to prevent permanent adhesion, is the apposition of such surfaces. Of course, after reunion of peritoneal surfaces, a certain

amount of plastic lymph is thrown out over the line of union, and if an opposing intestinal surface is allowed to remain in contact for any length of time, some peritoneal adhesion will take place. To prevent this, immediate and free peristaltic movement is, I believe, the best counteracting agent, and it is probable that among the good results which follow early purgation after cœliotomy this is not one of the least. But even should peritoneal adhesion occur, I believe that if merely traumatic, and not associated with a tuberculous taint, it is essentially flimsy and temporary. Some years ago I published in the *Medical Chronicle* a series of microphotographs showing the changes which took place in reunited intestine, which throw some light on this point, and which I show. Slide 9 shows such union after fourteen days. Slide 10 after two months. Slide 11 after three months have elapsed.

It will be seen that this peritoneal lymph is rapidly absorbed when once its object is obtained, and that the peritoneal surfaces tend to return to their normally smooth condition.

A very instructive case also illustrating this point is reported by Küstner, who removed a large tumour having firm adhesions to parietal peritoneum, omentum, bladder, fundus uteri, broad ligament and sigmoid flexure. The adhesions were carefully separated by the fingers, and by the thermo-cautery, which seals up all connective tissue. Coils of intestine were adherent and matted together. These were also separated with great care. Fourteen months later a second laparotomy for ventral hernia showed an entire absence of all adhesions.

But it is far otherwise if adhesion has taken place between the peritoneal surface of the gut, and some raw connective tissue surface, such as is found on the exposed end of a stump, the edge of an open vaginal wound, or that of the abdominal incision, when the peritoneal surfaces are not accurately closed. It will be seen that this also is another reason for the tier suture, since no through

and through suture can so absolutely prevent the possibility of exposure of some point of connective tissue between the edges of peritoneum, as one devoted entirely to that purpose.

That this is not a theoretical danger merely, is shown by Fritsch's case, in which the bowel was found adherent between the edges of the wound in a space between two sutures; Spencer Wells' case of adhesion between the bowel and the pedicle of an ovarian tumour; Ross' case, in which death occurred five weeks after abdominal hysterectomy. At the *post mortem*, "a small portion of intestine had become adherent to the abdominal incision, and another loop had slipped through above this adhesion between the bowel behind, and the abdominal wall in front, and had thus become obstructed;" Nieberding's case of intestine adherent to the margin of the wound, with consequent volvulus, and many others. Rohè says that "it is well known that intestinal or omental adhesions to the margins of the incision are found in nearly every case in which the abdomen is opened subsequent to laparotomy." But the most prominent instance in which this question arises is in the much disputed one of the closure of the pelvic peritoneum after panhysterectomy, and especially after the vaginal form of this operation. Many surgeons still advise that no effort should be made to close this structure. After removal of the uterus, the ligatures being drawn down into the vagina, and each lateral set being held apart, gauze is passed up between them into the pouch of Douglas, and made to project somewhat into the cavity of the peritoneum. I confess that I cannot see the reason of this. Given an ordinary vaginal hysterectomy with or without removal of the appendages, there should be *no* raw surfaces left above the level of the pelvic peritoneum. If the ligatures on the appendages and broad ligaments are left long, until after the closure by suture of the pelvic peritoneum above them, special care being taken at the extreme lateral points, these raw edges and ends can easily be drawn down into the



vaginal wound, and made extraperitoneal. When once the membrane is united above them, they cannot retract, and their ligatures may safely be cut short. What is left to drain above the re-united peritoneum? Blood? But this should have been previously removed by sponges. All possible bleeding surfaces are now outside, and no more blood can possibly find an entrance. Secretion from raw surfaces? But there are no raw surfaces left. The normal secretion of the peritoneum? Why? To what end? Any possible bacteria which may have found an entrance? But Clark has abundantly shown that the peritoneum itself is far more capable of dealing with these than we can by any method we may devise.

In the case of a more extensive operation, where intra-abdominal adhesions exist to intestine, omentum, and other abdominal and pelvic viscera, I maintain that the abdominal or combined operation should be done. If the latter, the vaginal attachments being separated, the uterine arteries tied, and the bladder more or less peeled off, the remaining steps are far more safely carried out from above, whilst these are most easily and rapidly done from below. Then the patient, being in the Trendelenburg position, and the abdominal wall being as widely open as may be necessary, adhesions may be separated in the peritoneal line, not blindly torn apart. Should any raw surfaces be left, the mobile peritoneum can be drawn over them, or omental grafts placed, so that when the operation is finished once more a plain peritoneal surface is left, which requires no drainage.

But it has been said, why take up all this time? Why not content ourselves with leaving gauze between the vaginal edges, projecting into the peritoneum? No harm ever comes of this. At a meeting of the North of England Gynæcological Society, last March, one speaker said:—"It matters little whether or not the peritoneum and the vaginal roof be brought together by suture, intestinal protrusion being very rare." Within twenty-four hours it is supposed

to be shut off from the general peritoneal cavity by a layer of lymph which effectively prevents any connection between the vagina and the parts above, whilst we have the satisfaction of feeling that we are draining all possible points, and moreover, our gauze is acting as a support to the intestines, and preventing them from prolapse. Besides, it is so much more easily and quickly done, and we shall be able to boast that we did a vaginal hysterectomy in fifteen minutes ten seconds, five minutes and three seconds less than the last recorded operation. But in the first place, is it true that no harm ever follows? Coe<sup>1</sup> has recorded three cases in his own practice, and eight in those of others, in which adhesion took place between a coil of intestine, and the raw edge of the vaginal wound so left open; all these cases ended fatally. Reichel<sup>2</sup> reports three cases, all fatal. Leopold, Landau and Bokelmann have each had a case, each and all of which were followed by death. Giresse<sup>3</sup> suggests that in any such case a vaginal anus should be formed. Is that a condition which any of us could regard as a satisfactory final result to a hysterectomy? Would not death almost be preferable? As to the idea of preventing prolapse, there might be something in it if this gauze were to remain for any length of time, but it must be removed within eight to ten days, at the furthest, and then the intestinal pressure comes to bear not upon a contracted vagina, such as is found after suture of peritoneum and the presence of a mere strip of gauze below, but upon a widely open vagina closed above by a layer of lymph, one of the weakest boundaries possible, and which is bound to yield to intra-abdominal tension. The chances of sequent vaginal prolapse are, it will be seen, greatly increased instead of diminished by this manœuvre. Vaginal prolapse is said by some, as by Landau, not to occur after vaginal hysterectomy.

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<sup>1</sup> *Am. Journ. Obst.*, 1897, vol. i., p. 81.

<sup>2</sup> *Zeitschr. f. Geb. u. Gyn.*, Bd. xv., Hft. 1.

<sup>3</sup> *Thèse de Paris*, 1896.

tomy, but the cases of Baldy,<sup>4</sup> Byrom Robinson,<sup>5</sup> and Ferguson<sup>6</sup> prove the contrary. Gardner, of Montreal, also says in a private letter to me, that in some cases, especially in parous women, there has been a troublesome tendency to prolapse. Professor Baldy, in a similar letter, says this occurs very rarely in his practice, and lays stress upon his method of gathering up the broad ligaments in such a way by ligatures and sutures as to prevent this occurrence.

Other results sometimes follow, thus Fraenkel<sup>7</sup> reports a case in which the omentum prolapsed outside the vulva on the third day after vaginal extirpation by the clamp method (Landau's) and Medanie<sup>8</sup> of the Klinik Rokitansky, reported a case in which he observed such a prolapse three months after the operation, which was performed by Schauta, had been done. Dr. Snow, at the May meeting, mentioned a case in which a plug of omentum occupied the upper extremity of the vagina, and discharged a small quantity of fluid every day. Such an adhesion must necessarily imply a persistent pull upon the transverse colon and stomach, and be likely to induce later dyspeptic troubles. Are we justified in causing the patient to run these risks whilst they are preventable, merely because it is easier, or in order that we may do an operation under record time, and such as will bear reproduction by the cinematograph? But reunion of the peritoneal flaps alone must not be confused as it was by the speaker already referred to with union of peritoneum *and* the raw surfaces beneath. There is no fear, if hæmostasis has been thorough and the peritoneal currents are well in action in a perfectly closed sac, of any banking up of deleterious fluids *inside* the peritoneum. There may very well be if the accumulation takes place between the raw surfaces now below that membrane.

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<sup>4</sup> *Am. Journ. Obst.*, 1897, vol. i., p. 81.

<sup>5</sup> *Am. Gyn. Journ.*, Oct., 1897.

<sup>6</sup> *Am. Journ. Obst.*, 1897, vol. i., p. 890.

<sup>7</sup> *Centralb. für Gynäk.*, 1898, p. 495.

<sup>8</sup> *Ibid.*, p. 375.

If such fluids have not a ready exit *per vaginam*, the tension so produced may have serious results; and for this reason it would appear that the application of a gauze drain to the parts below the pelvic serous membrane is a wise precaution.

Persistent sinuses are not often seen now that the supra-pubic drainage tube is given up. The tube would appear to have been a prolific cause of this. In an early case of my own, I have seen fæcal fistula which was due entirely to its use. When a sinus does result, it is due in the great majority of cases to an imperfectly sterilised ligature or suture. In this direction, there would seem to be still room for improvement. The sterilisation of catgut and kangaroo tendon by Krönig's cumol method, by Pozzi's juniper, or the later formalin process, leaves much to be desired. Macnaughton-Jones keeps his catgut, after using the juniper method, for six weeks in alcohol; possibly this may account for the better results he obtains with it. Catgut sterilised by formalin is much too brittle; and I have been forced, rather against my will, to abandon this material, and to trust entirely to silk for intra-peritoneal work, because it can be so thoroughly purified by steam under a pressure of two kilos in a steriliser. But silk, when fine, must be plaited, and this does not so readily absorb. All foreign bodies which remain unchanged for any length of time, are possible sources of danger in the future; possible sources of pain or disappointing after effects; these we want to eliminate entirely. How can this be done?

Some other evil results remain to be considered. In February of this year Mr. Charles Ryall brought forward a case in which death ensued in consequence of gangrene following embolism of the posterior tibial artery, and Mr. Jessett mentioned a case of hemiplegia which he thought possibly might be due to embolism. He remarked that phlegmasia dolens also was common after hysterectomy. Is it possible that this is due to the non-ligature of the valveless veins in the pelvic connective tissue as Zweifel suggests, which do not necessarily bleed at the moment.



If so, Jonnesco's suggestion that we should not ligature the broad ligaments *en masse*, but only the actual spouting arteries, whilst very attractive, as apparently a neater and more surgical procedure, would render this danger still more probable. Has anyone any experience of Skene's method of clamping, by means of forceps which are rendered electrically thermocautistic? It would seem that if this method is practicable it would, by sealing all the divided tissues, provide a means of prevention. Speaking without personal experience, however, one would fear that the necessity of providing a battery capable of heating these forceps to the necessary temperature, and especially of heating a sufficient number at the same time, will considerably limit its sphere of utility.

We must all have noted, also, the occurrence in exceptional cases of persistent sacralgia after the most careful operations. Cases in which apparently there are no adhesions, none at least which hamper in any way the free action of the bowels or bladder. Are we to explain such cases by the inclusion in our ligatures of certain sympathetic nerve fibres? and the formation, perhaps, of traumatic neuromata? If so, how is this to be avoided? If Skene's forceps were available, we might hope so to immediately kill these nerve ends by cauterisation that they would cease at once and permanently to receive and transmit sensations. The tissue in the grip of such forceps would be transformed into a semi-translucent, horny film, in which all traces of organisation would be lost. Lymphatics would be sealed, arteries and veins definitely and aseptically closed, and nerves destroyed. Theoretically this method appears to promise much. Is it practicable? and if so, is there evidence available as to its final results? I confess that I have not as yet been able to find any. Angiotripsy by Doyen's or Thumin's lever clamps would not be certain to produce a similar condition; besides which, all clamps that are not at the same time thermocauteries leave sloughs which cannot be, as the others

are, quietly absorbed, but must be thrown off, with all the possibilities of septic infection during the process. Mackenrodt has, moreover, pointed out the danger of the bulky angiotribes with reference to the ureters. This neuromatous condition, *if it is one*, also must be avoided if we are to obtain satisfactory after-results. How is it to be done?

I trust that before long answers to all these questions will be found, if they are not definitely cleared up by later speakers in the present discussion, for I feel certain that in attention to these, which may appear at first sight almost trivial details, is to be found that perfect final result at which we all aim, and which it is, in our patients' interest, as also in our own, imperative that we should obtain.

Dr. HEYWOOD SMITH remarked that he still thought that subperitoneal hysterectomy was safer than panhysterectomy. Mr. Stanmore Bishop grouped these two operations together, but in view of their different mortality they were better considered apart. The risk of ventral hernia would be minimised by making the abdominal incision not through the linea alba, but half an inch to one or the other side.

Dr. C. H. F. ROUTH remarked that any operation that might be considered would be found to have met with considerable opposition in the first instance; and moreover, the mortality was always higher at the first. He had seen some operations done very badly and others very well; but, curiously enough, the mortality among those that were well done was often not less, and might be even greater, than the others. He had also often seen mistakes made in diagnosis, and yet the operation succeeded whether the diagnosis was right or wrong. Then, again, one man said, "If you are not operated on, you will be dead in eighteen months;" whilst another said, "If you are operated on, you will be dead much sooner." These considerations often made the question of operation a very difficult one to decide.

Mr. CHRISTOPHER MARTIN (Birmingham), in contrasting the various plans of hysterectomy, said that he failed to see what good the cervix could do after the rest of the uterus had been removed. The objection that the removal of the cervix weakened the vaginal vault was, he believed, a purely imaginary one; he had never seen any vaginal prolapse after panhysterectomy. There was, in some cases, a tendency to malignant degeneration in the cervical stump, when this was left; and for this reason it was better to take away the whole uterus. He had seen several instances of this. With regard to the value of purgation, he thought that Mr. Bishop's explanation of its *modus operandi* was too mechanical; there was, in addition, a vital action present, probably of a bactericidal character. Referring to the question of ventral hernia, he said that he was at one time much opposed to the use of buried sutures; but since adopting the late Mr. Greig Smith's suggestion of boiling chromicised catgut in xylol or absolute alcohol, he had never seen any bad results in the way of stitch-abscesses; and the plan of sewing up in layers was, in his opinion, the best.

Dr. MACNAUGHTON-JONES, referring to Mr. Bishop's statement that fatality was due most often to delay, next, to sepsis, said that his own view was that delay led to sepsis, since this was favoured by all the accidents due to delay, such as hæmorrhage, sloughing, &c. In discussing the indications for hysterectomy, the question was: If hysterectomy were not done, what were the alternatives? They might do nothing, or advise oöphorectomy or ligation of the uterine arteries; but in either case the patient had her tumour left. The same rules applied to gynæcological as to other branches of surgery; and he quite agreed with Mr. Bishop that cases requiring operation should be done as soon as possible. He had had only two cases of ventral hernia following operation, one in which the patient was mentally unstable, and did her best to tear open the wound; and the other where it came on

after violent retching, due to sea-sickness. He was quite satisfied with his method, which was the plan of sewing up in three layers; he never had any trouble with buried sutures. The form of operation for hysterectomy which he preferred was the supravaginal, at the same time he quite agreed with the view expressed by the President on a former occasion, that each surgeon was safest in performing the operation to which he was most accustomed.

Dr. E. T. DAVIES (Liverpool) said that in cases of fibroids, where there were no symptoms, it was very difficult to know whether to advise operation or not. Thus he had a patient whom he had kept under observation for six or seven years; she had no inconvenience from the tumour except from the æsthetic point of view. In his somewhat limited experience of hysterectomy he had always done Baer's operation; but with regard to the stump, he did not think it was of any importance in maintaining the vaginal vault, for no inconvenience was observed in cases where the uterus was completely removed by the vagina for cancer. Baer's operation was, however, easier, and asepsis was more readily secured. It was not necessary to make much of a posterior flap; in fact, the less of it that was left the better. Malignant degeneration of the stump and of fibromyomata generally was, he thought, something of a bugbear; he had read of the occurrence, but had never seen a case. In the matter of purgation his plan was to give an aperient after twenty-four hours. He had been disappointed with buried sutures for closing the parietal incision, though he had tried silk, silkworm gut, and catgut, for he had had stitch-abscesses; so he had gone back to the through and through method, and had had no suppuration in these cases. The celloidin dressing seemed to be a good one, and he would like to try it in some of his future cases.

Mr. CHARLES RYALL observed that peritonitis might be set up in two ways—by introduction of organisms from without, and by infection from the bowel. If there was



much handling of the bowel, infection was more likely to occur. He had been very interested in Muscatello's experiments, and had adopted his suggestion of raising the foot of the bed to increase the lymph stream through the diaphragm, and of leaving two pints of salt solution in the peritoneal cavity in cases where he had been afraid of sepsis. Hernia was in some cases due to the use of drainage through the abdominal wall; and he had never adopted this plan without regretting it. The best way to drain was through the pouch of Douglas, or by Muscatello's plan above mentioned. Stitch-abscesses were in some cases unavoidable, especially when intestine had been injured, for then the hands were liable to get infected. Dr. Macnaughton-Jones had already referred to one evil result, viz., sloughing of the stump; there was another that had not been mentioned, viz., malignant infection of the wound. In abdominal section for cancer, it was very important not to allow the growth to come in contact with the abdominal wall.

Dr. ROBERT BELL (Glasgow) said that the danger in opening the abdomen was due, in his opinion, entirely to sepsis. But it was only when the septic material was in a condition for absorption that sepsis could occur. The view that sepsis could arise by absorption from the bowel appeared to him to be entirely theoretical; if that view were correct, why should not infection result from constipation? Like some previous speakers he advocated the method of supravaginal hysterectomy, which had always given him very good results. The number of cases of hernia following abdominal section was appalling; he was not speaking from his own experience, for he had only had one case himself. To prevent it, the first thing was to close the peritoneum completely. This then allowed the operator to take proper time for the closing of the outer part of the wound, which was the important part. By this means there was never any suppuration, and if healing took place by first intention, hernia would never occur. It was important also to remember that the smaller the wound, the better.

Mr. J. W. DRAPER (Huddersfield) said the cases that had been under his observation in general practice (about 15 cases) had not been subjected to hysterectomy. In one the ovaries had been removed. In another, a case of small pedunculated fibroid producing pressure symptoms, the tumour had been removed. Of these cases none had died of their disease. Most had passed the menopause. One had married when over 50 years of age without ill consequences. Some had suffered from hæmorrhages and had been treated by rest and medicines. On the whole he believed these patients had enjoyed a better life, in spite of the lumps they carried about inside them, than they would have done if they had been operated on. Perhaps his cases had been mild ones. They were as they occurred in his practice. The presence of a tumour did not cause him to advise operation unless he saw rocks ahead. They required watching.

The PRESIDENT said that his experience had been very different from that of the last speaker, for he had seen very bad consequences from not operating in cases of myoma. He had seen a large myoma forced down into the vagina, and suppurating there, the patient being at death's door; he had seen malignant degeneration, sloughing, and dangerous hæmorrhages. It had been noticed that in speaking of the risk of hernia every one seemed best satisfied with the particular method of suture that he had most recently adopted; also, most operators found hernias in the practice of other men, but not in their own. This was because, naturally, the patient did not come back to the man who had given her a hernia. His own plan was to be careful to secure the fascia, using boiled catgut. It did not seem to him that a strong case had been made out for celloidin; if a wound were aseptic, it would heal whatever the dressing; and if it were not aseptic, it seemed to him that celloidin would be a disadvantage.

Mr. STANMORE BISHOP, in reply, said that the union of the fascia appeared to him the one important point in the

prevention of hernia. He judged of the value of different plans for the prevention of hernia, not from other men's cases, but from his own ; for formerly a certain proportion of his patients used to come back to him with hernia, and he used to be greatly exercised how to prevent it ; he tried one plan after another, but it was not until he adopted the plan of carefully securing the fascia that he had got good results. This plan he had now used for seven years, and since then none of his patients had returned with hernia. Mr. Martin had asked him whether by vaginal prolapse he meant prolapse of the vaginal walls or protrusion of intestine into the vagina. It was the latter complication that he referred to. Prolapse of intestine into and through the vagina had been noted in cases where the peritoneum had not been closed ; and he believed that this accident might follow the introduction of gauze between the flaps into the peritoneal cavity ; besides which, this procedure left a way open for the entrance of infective material.

*BRITISH GYNÆCOLOGICAL SOCIETY.*

THURSDAY, OCTOBER 11, 1900.

W. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

CASE I.—LARGE FIBROID OF THE RIGHT BROAD LIGAMENT, WEIGHING 16 LBS. ABDOMINAL HYSTERECTOMY—RECOVERY. By FRED. BOWREMAN JESSETT, F.R.C.S. Surgeon to the Cancer Hospital and Gordon Hospital for Fistula.

Mrs. C., aged 48, five children, youngest 7 years of age.

On June 29 of this year Dr. Maturin asked me to see this patient with him. She had been confined to her bed for some time, and suffered from great pain and œdema of the legs, which were considerably swollen. She had suffered for some years from a large tumour in the abdomen, for which she had consulted on different occasions two of our leading obstetric physicians, who had advised her to let matters be, and possibly at the menopause the tumour might commence to decrease in size. From the size of the tumour she was quite incapacitated from doing anything, or, indeed, from getting about at all. She suffered from considerable loss at her periods, her breathing was much impeded, and her pulse was weak and rapid. In consultation with Dr. Maturin I advised, as the only means of giving her relief, the removal of the tumour, at the same time pointing out that there might be considerable risk attaching to the operation owing to the size of the tumour and the enfeebled condition of the patient. She, however, was anxious and willing to run the risk,



as her life, in her present state, was more or less a burden to her.

On July 2 she came to town and was admitted into a home, and on the 4th, with the assistance of Dr. Purcell and Dr. Maturin, Dr. English giving ether, I proceeded to operate.

On opening the abdomen in the middle line the tumour at once presented itself, and, by means of the corkscrew, was readily delivered; the cæcum and vermiform appendix were seen lying on the tumour somewhat to the right. I divided the peritoneum and readily stripped these from off the tumour. On the left side a hard flattened tumour of the size of a large pear was seen situated apparently in the left broad ligament. The ovary and Fallopian tube being situated to the outer side of this I proceeded to ligature and divide the broad ligament well down on the left side. The right ovary and tube could not be defined; the round ligament, however, was differentiated, and some very large veins. These were ligatured in two places and divided. The bladder extended some way up the tumour. I divided the peritoneum and stripped it off, and by exercising some force pulled the remainder of the tumour out of the pelvis, the vaginal wall presented, and Mr. Robinson passed a long pair of uterine forceps *per vaginam*, thus defining the roof of vagina, which I opened up by cutting down upon the forceps; then I had no difficulty in removing the whole growth, having first clamped the uterine arteries on either side. I passed a good-sized piece of iodoform gauze through the vagina, and left it to act as a drain, ligatured all bleeding points, and stitched the peritoneum over the floor of the pelvis.

The patient was very collapsed after the operation, but steadily rallied, and made an even and uneventful recovery.

On examining the specimen it was found that the small tumour at the left side of the larger one was in reality the uterus, and the right ovary and tube were stretched

and flattened over the tumour, and so tense that it was impossible at the time of the operation to differentiate them. Had I done so, it would have been quite possible to have enucleated the large fibroid and drained the cavity through the vagina and saved the uterus and the left ovary.

CASE II.—FIBRO-CYSTIC TUMOUR OF THE UTERUS. THE CYST CONTAINING A LARGE QUANTITY OF FLUID BLOOD. REMOVED BY ABDOMINAL SECTION—RECOVERY.

Mrs. M., aged 44, no children, was sent to me by Dr. Inglis, Hastings, on July 20, suffering from an abdominal tumour.

Some months prior to consulting me she had an attack of acute pain in the right iliac fossa, which only lasted a few days and then subsided. On June 16 she had a return of the pain, which was very acute and extended over the whole abdomen, and obliged her to take to her bed, and ended in a sharp attack of peritonitis, with a temperature of 103° F. This gradually subsided, and a tumour was then discovered rising from the pelvis. This increased somewhat rapidly. She had been married five years. No children or miscarriage. Periods regular but scanty, and she had no pain at these times. The abdomen was smooth and flaccid, but at the lower part of the abdomen, slightly to the right of the middle line, a distinct fulness could be detected extending to within an inch of the umbilicus. The tumour was smooth, and distinct elasticity could be felt, it was slightly movable, and pressure on the right side caused some pain. *Per vaginam* nothing particular could be felt, but bi-manual examination indicated that the tumour was connected with the uterus. Nothing further could be discovered *per rectum*.

The diagnosis of this case was somewhat obscure, as the history had many of the symptoms of an attack of

appendicitis in the first instance, but at the present time a cystic tumour was recognised, which was too central apparently for ovarian, but yet had to the touch all the indications of broad ligament cyst, or an ovarian cyst with a very short pedicle; the latter diagnosis was favoured by me, and I thought the acute symptoms from which she had suffered were the result of twisting of the pedicle.

*July 23.—Operation.*—With the assistance of Mr. Ryall, Dr. English administering the anæsthetic, I opened the abdomen in the mesial line, when the tumour immediately presented, and had much the appearance of a pregnant uterus of some five or six months. The tumour was composed apparently of muscular tissue and contained fluid. By careful examination, however, the uterus was found to be on the left of the cyst, but the walls of the cyst were evidently continuous with the uterine tissue, but no foreign body could be felt in it. There was a considerable quantity of adhesion at the posterior surface and in the pelvis.

The tumour having been delivered from the abdomen through the abdominal incision, I proceeded to ligature the broad ligaments and removed the uterus with the cyst by the sub-peritoneal operation.

The patient made an excellent recovery and is now quite in her usual health.

The pathologist's report is to the effect that the cyst has all the appearance of a sarcomatous growth.

*Remarks.*—I venture to report this case as I can find no report of any case that seems to clearly describe the condition.

If you will examine the specimen you will see that a probe passed into the cavity of the uterus appears to pass through an opening, apparently the opening into the Fallopian tube, and the question naturally arises—can this be a case of single-horned uterus with stenosis of the opening into uterine cavity and accumulation of menstrual fluid? Against this theory might be urged—why should this sudden accumulation and rapid growth take place? Again, can

this be a case of fibro-cystic tumour of the uterus in which necrobiosis has taken place, with extravasation of blood into the cyst? L. Championnière (*Bull. et Mém. de la Soc. de Chir.*, 1889, p. 196) has quoted the case of a fibroid in the centre of which was a collection of material within, which he likens to a hæmatocele. Lastly, is this a specimen of a fibroid undergoing sarcomatous degeneration, in which myo-sarcomatous tissue cystic change has taken place by softening and apoplectic effusion of blood? The pathologist's report seems to point to this latter explanation, as he reports that he believes it to be sarcoma.

CASE III.—LARGE HYDRO-NEPHROSIS ON THE RIGHT SIDE  
MISTAKEN FOR OVARIAN CYST OR HYDATID. OPERATION—RECOVERY.

A single woman, aged 38, shop assistant, was admitted on February 10, 1900, complaining of pain and swelling in right iliac and lumbar region. She had had no previous illness, having been always healthy until six years ago, when she said she had a great deal of sickness, and pain in this region, radiating down the thigh. On lying down it used to disappear. She saw a medical man, who advised rest. About three years ago she noticed a small lump in the abdomen, the pain was less than before, but worse on lying on that side. The lump is now increasing in size and the pain is getting worse. The pain she describes as "dragging from the loins, and the hip bone gets sore." She has been sent from the Gordon Hospital here. The pain makes her feel sick and shoots down the thigh. The tumour fluctuates in size.

*Present Condition.*—On inspection the abdomen appears slightly distended, and on the right side a distinct enlargement is noticed. *Palpation.*—The abdomen is normal in all respects except in the umbilical, right lumbar, and right iliac regions; here a swelling is noticed, which is rounded, it is not painful, the fingers can be put between it and the



ribs, and it does not appear to go into the pelvis below, but over the umbilical region it is felt to go slightly beyond the mid-line. It is freely movable, and moves on pressure from the loins. Percussion over the apex of the tumour is dull. Bowels rather confined. Urinary system : no pain, no blood, but frequently has to get up at night to pass water ; sometimes she passes a good deal more than others. Urine : 1,025, acid, no abnormal constituents. Menstruation : regular, twenty-eight days ; used to lose a good deal, now loses very little ; used to last a week, now only three days ; last, a fortnight since, no pain. Heart normal, pulse 76, volume fair. Lungs : few ronchi at left apex.

On February 20, with the assistance of Mr. Robinson, I opened the abdomen in the middle line over the cyst. On examination it was found to be situated behind the gastro-colic omentum, to which it was intimately adherent. On carefully tearing through this I discovered the cyst was completely retro-peritoneal. I then divided the peritoneum over the cyst with a view of stripping it off and drawing the cyst out. I found, however, it ascended quite to the diaphragm behind the liver, and downwards to the pelvis. I decided, therefore, to stitch the cyst wall to the abdominal wound, catching up at the same time the gastro-colic omentum, I tapped the cyst and drew off about two quarts of clear fluid, quite colourless and free from any smell. I then opened the cyst and passed my hand into it with a view of trying to draw it out. There were no hooklets or signs of hydatid. I introduced a large india rubber drainage tube and returned the patient to bed. She made an excellent recovery, and I hoped the cyst might have shrivelled and become obliterated. The contents of the cyst were carefully examined, and pronounced not to have any of the characteristics of urine. The patient left the hospital on March 20. On May 18 she presented herself again. The sinus was still discharging pretty freely a purulent fluid, and the probe passed readily for some eight inches. The patient was very anxious to have something more done for

her, and after explaining the risks and rather discouraging any further interference, she elected to have another operation performed, with a view of removing the cyst wall.

On June 22 I operated by making an incision through the right linea alba, extending from the ribs downwards for about five inches. I opened the peritoneum, and then had a sound passed into the sinus leading to the cyst to try and define the walls; this, however, was not satisfactory, so I had a quantity of sterilised water injected through the sinus, which did all I required. An assistant kept his finger over the opening, and I divided the peritoneum just in front of the ascending colon, and stripped it off the cyst wall anteriorly until I arrived at the point where it was attached to the gastro-colic omentum. I then let the watery contents out, clamped the ends, and divided it, then by carefully peeling backwards I got quite back to the loin, and found kidney substance. I ligatured the vessels, and with but little difficulty removed the whole cyst. I then proceeded to stitch the peritoneum together with catgut, and introduced a large-sized rubber drainage tube through the abdominal wound, which was next closed. The patient bore the operation very well, and made a good convalescence, although the silk ligatures caused a little trouble. The patient left the hospital on July 12, still having a sinus leading down to the loin, which was kept open by the irritation of the ligatures, and it was not until September that the last ligature came away and the sinus closed.

The anterior sinus I treated by paring the edges and inverting the cut edges of the cyst, drawing them through the abdominal opening and fixing it to the parietal opening.

*Remarks.* — This case is one of considerable interest, owing to the difficulties of diagnosis; it had been severally diagnosed as ovarian, hydatid, and distended gall-bladder, but nobody recognised its real character. Then, when the cyst was tapped after the first operation, one would have expected the fluid would have had some of the distinguishing characteristics of urine, but there were none, so that

even after the first operation I concluded we had to deal with a simple retro-peritoneal cyst. Then as to the treatment, I think I did the thing which was most to the interest of my patient by, in the first instance, simply fixing the cyst wall to the parietal wound and draining, with the hopes that the cyst might become obliterated, either by shrinkage, or by the lining membrane taking on some inflammatory action.

CASE OF MYOMATOUS UTERUS REMOVED BY ABDOMINAL HYSTERECTOMY. Under the care of HERBERT SNOW, M.D.Lond.

The patient was a children's nurse, aged 45, who had made a favourable recovery. The tumour was increasing rapidly, and interfered with her occupation. It was a large nodular mass, with the uterine body deeply buried within the multiple myomata. The ground-plan suggested that of a clover-leaf. A central prominent boss, extensively adherent to the bladder, extended above the umbilicus; on each side a group of smaller ones burrowed deeply behind the broad ligament. The absence of suffering complained of with such an extensive growth was remarkable.

In suturing the abdominal parietes Dr. Snow had employed what he had previously suggested to the Society as the ideal method. The old plan of suture through all the layers was apt to be followed by stitch-abscess and parietal hernia. The newer, of sewing up each layer separately, involved the risk of peritoneal rupture should the patient become delirious or hysterical. By first passing three silkworm-gut sutures through the entire parietes, then sewing up the peritoneum with catgut, and lastly uniting the extra-peritoneal layers with silk, these disadvantages were obviated. The other plans commonly answered well, but he thought the wisest surgeon would always strive to eliminate the least chance of failure, as by this simple combination of the two.

CASE OF FIBROMA OF THE BROAD LIGAMENT. Under the care of FREDERICK EDGE, M.D.Lond., F.R.C.S.

The patient was aged 37. Pressure symptoms led to the discovery of a solid tumour in the pelvis, to the left of the uterus. The abdomen was opened, the broad ligament split, and the tumour enucleated; after which the hole in the broad ligament was closed above. As the appendages were diseased they were also removed, and the abdomen was closed. The patient was then placed in the lithotomy position, and the cavity of the myoma was opened and drained from below. The patient made an uninterrupted recovery. The tumour was rather larger than a foetal head. Dr. Edge remarked that in another similar case he would open into the vagina from above, as it was not very easy to discover the collapsed cavity from the vagina.

Dr. F. A. PURCELL referred to the extraordinary elongation of the vagina, which was found in the first case; the uterus also formed a kind of comet-like extension on the surface of the tumour. In some cases it was desirable that a tumour of this kind should be removed while the uterus was left behind; but in this instance the tumour was so closely incorporated with the back of the uterus that it would scarcely have been possible.

The PRESIDENT said that in a former discussion as to the relative value of supra-vaginal hysterectomy and pan-hysterectomy, Dr. Edge spoke of the liability to the development of sarcoma in the stump; and by Dr. Edge and others this liability was regarded as an argument against leaving the cervix. At the meeting at Ipswich last summer, the occurrence of sarcoma in the stump was referred to as being so rare as to be scarcely worth considering, at any rate in deciding on the kind of operation to be done. This being so, he thought it was only fair that attention should be called to a case in which the development of sarcoma actually occurred in a myomatous uterus. Mr. Jessett's second specimen was apparently of this kind, and it would



probably have been better if the cervix had been removed in this case.

Dr. SEPTIMUS SUNDERLAND asked whether Mr. Jessett, in his operation on the case of hydronephrosis, had passed a sound down into the ureter to ascertain whether there was a stone in it.

Mr. JESSETT, in reply, said that he wished that he had removed the cervix in his second case ; but at the time of the operation there was nothing to show that it was a sarcoma. Indeed, he was even now a little sceptical as to its being really a case of sarcoma, and he would consequently like to have it referred to a pathological committee.

**"TREATMENT" IN GYNÆCOLOGICAL CASES. By HEYWOOD SMITH, M.A., M.D.Oxon.**

Seeing that gynæcology has advanced by rapid strides during the past fifteen or twenty years, an advance in our country due in no small measure to the steady work done by this Society ; seeing also that in the work thus done and papers read great predominance has been given to the surgical aspect of the subject, resulting in a vast improvement in the various and serious operations that the art of the gynæcologist demands, such as cœliotomy for hysterectomy, &c., so that the pendulum seems almost inclined to swing beyond its legitimate range, I thought it might not prove unprofitable if we were to devote an evening to the discussion of gynæcology from the medical standpoint, or rather from the "treatment" aspect ; for, notwithstanding that the general practitioner, thanks to the improved methods of instruction that are afforded to the student nowadays in special hospitals and post-graduate courses, embarks in the performance of more severe operations than he was wont to undertake in days gone by, yet those cases that come under the head of so-called "treatment" form by far the larger bulk of those seeking his advice, and on the proper handling of such cases, and the successful result, may depend much of his success and prosperity.

And here, perhaps, a word of explanation is necessary. It is too much impressed on the public mind that when we advise a patient to come for treatment into a medical home an operation necessarily follows, and the question is at once put, "Then do you consider an operation necessary?" and much of the shrinking such patients have from going into these homes is from an ill-defined feeling that they will sooner or later be operated upon. Though the title of my paper may seem rather vague, yet I have used the word "treatment" in the technical sense as evolved from patients frequently remarking, "Oh! I did not go there for an operation, but only for *treatment*."

At the outset of our investigation we are confronted with the difficulty of delimitation, or the right classification of cases, whether medical or surgical, general or local, and of operations or treatment, whether major or minor. And, when we come to think of it, the same difficulty seems to present itself in all hard and fast classification, and especially so when we attempt to define or assign its proper place to any procedure, whether of medicine or surgery.

In the various specialities is not the nomenclature, pathology, and treatment expressly local, even in medicine? as we see in diseases of the lungs, heart, liver, intestines, &c., and where speciality marks out one organ, or associated organs, as its region of activity or investigation, is it not so that the very localisation of the speciality pushes it into the domain of surgery?

Yet another difficulty presents itself to us in this consideration of operation *versus* treatment, and that is implied in the terms we often use of *major* and *minor*. Now, some operations are termed *major*, as, *e.g.*, cœliotomy, whether for hysterectomy or for the removal of the appendages, and others *minor*, as curetting or ignipuncture of the cervix; yet it may happen that with our improved asepsis the so-called major operation may be less risky than *e.g.*, curetting in the hands of one inexperienced, or, who, deeming it a minor operation, brings to bear upon it less scrupulous care

and attention than he would give to a major operation. So again in the prognosis to the patient of the result of various methods of procedure we may be at a loss to explain whether a so-called minor prolonged treatment is less or more likely to produce a definite result than some royal road by a so-called major operation. And, lastly, with regard to the ultimate risk to life as presented to the patient it is by no means easy to persuade either her or ourselves that some minor method is safer than a major operation, since some operators have been able to report over 100 cœliotomies, many of them presenting grave complications, without a single death.

In the consideration of our subject we come now to another difficulty. How are we to differentiate a line of treatment that is technically called "treatment," so that it does not encroach on the domain of surgery? Surgery aims at the *tangible*, and in our speciality the uterus is directly tangible, and the ovaries and the oviducts, under certain conditions, indirectly so, as through the vaginal roof or rectum. But so, also, to a physician, is an inflamed kidney, and, partially so, a dilated stomach or consolidated lung.

Bearing in mind, then, the difficulties of delimitation, and how almost impossible it is to say, especially in our speciality, where surgery ends and medicine begins, I will endeavour to point out those cases which are likely, not, perhaps, to be so much overlooked, as neglected or passed by as less interesting, and, may I venture to say, less profitable than those brilliant and fascinating operations that the *cacoethes operandi* beguiles the facile operator to undertake.

Then there is one more element that enters into our calculation, and that is *time*. To some patients time may be a consideration, and it may make a considerable difference to them whether they have to lie up for two or three months or longer, or whether we can hold out to them the prospect of a cure in three or four weeks if they are willing to undergo an operation. And for ourselves, and I speak

as an operator myself, does not sometimes the glamour of a brilliant operation weigh somewhat in our minds when deciding whether we should recommend an operation, or whether, having due regard in the first place to the patient's well being, we advise, even at the expenditure of more time, and the exercise of considerable patience, that she should undergo a line of treatment that may be both tedious and unpleasant, but which, we hope, in the end will result in a cure not less probable than is held out by some operative interference ?

The rôle of woman is, as that of a flower, to bring forth fruit, and in fulfilling that rôle, the organs of reproduction, if used aright, will be maintained in a condition of health, yet in some cases the organs may suffer through that very use, legitimate though it be. Yet it more frequently happens that an unused organ, as the mamma, becomes the seat of disease, than one that has borne its proper share of galactiferous activity. On the other hand, diseases of the cervix uteri are more often met with in those who have borne children—but of this more hereafter.

#### MISPLACEMENTS.

Misplacements of the uterus occur both in the married and in the unmarried. With the latter they more often occur in those who are active and hard-worked, from sudden strains concomitant with a full bladder or rectum, or in the case of ante flexion it may be the exaggeration of the congenital form determined by habitual constipation or strain. But am I here treading on surgical toes ? I think not, as regards the early manifestation of these cases ; it is only when they have resisted treatment that the surgeon gets hold of them and does Alexander's operation, or ventrofixation, or some more elaborate cobbling. Patient treatment by depletion followed by reposition and retention by a proper appliance in many cases results in a cure ; so also, after a time, and especially in the married, where the mis-



placement has been followed by chronic inflammation "treatment," in its technical sense, becomes of value, and these sequelæ yield to methods that the pure gynæcological surgeon scarcely thinks it worth his while to undertake.

### CHRONIC INFLAMMATION.

Acute metritis is rare in the unmarried, and, as such, comes under the domain of the physician. Of the chronic inflammations of the uterus, chronic metritis (rare), chronic cervicitis with subsequent induration, chronic endometritis, and chronic endocervicitis are all in various degrees amenable to treatment; the process of cure takes time and needs much patience. The chief indications are depletion first of all either by leeches or scarification, followed by a course of glycerine plugs and douches as hot as can be borne; then, when the organ is thereby rendered able to bear more direct treatment without the fear of setting up more mischief, the special feature of the inflammatory product can be attacked. In cases of endometritis, where the characteristic symptoms are pain on passing the sound and a glairy discharge entangling small clots about the size of a pea, dilatation of the uterine cavity, and the application of iodised phenol often lead to a good result.

I have brought here some wooden stems which will be found useful, as, when covered with cotton wool and dipped into the preparation, they can be passed into the uterus and retained for twenty or forty-eight hours.

Where chronic cervicitis has existed for some time, the cervical tissue becomes indurated by the proliferation and compression of the connective tissue. This has to be got rid of before the characteristic back-ache is relieved. Here it becomes necessary to destroy the adventitious tissue, and this is best done by the actual cautery in the shape of a large button, which can be applied to the bulky cervix, or by the flat point by which we can attack the induration when it bulges into the cervical canal, or by the free igni-

puncture of the cervix. Where the induration is of considerable size and fibroid hardness there is no treatment more successful than its removal by potassa caustica, a full description of this treatment and the precautions to be used is given in the recently published second edition of my book on "Practical Gynæcology." This treatment, however, needs patience and care.

In the treatment of these cases the exhibition of the perchloride of mercury, followed by the iodide of potassium, is of great service, and during the treatment of induration of the cervix the extrusion of the indurated tissue after cauterisation is greatly helped by a course of ergot. Then there is that condition of the cervix, seen not only in cases of chronic cervicitis with induration, but in cases in an earlier stage without induration that some practitioners still persist in calling "ulceration" of the uterus. It is not so, but is analogous to a red granular tonsil, and is rightly called "granular inflammation" of the lips of the uterus. This will generally yield to depletions, glycerine plugs, or poulticing of the cervix, followed by the application of strong carbolic acid, acid nitrate of mercury, Friar's balsam, or *pinus canadensis*.

#### FIBROUS TUMOUR.

The Society has of recent years prosecuted inquiry into the history and surgical treatment of fibrous tumours of the uterus, and it would be outside the scope of this paper to make more particular reference to this disease here; but as not foreign to my subject I would impress on practitioners the expediency of, at all events, making an attempt to treat these cases in their very early stage by following the suggestion of Dr. Robert Bell, of giving a course of the extract of mammary gland. Inasmuch as fibroid enlargement of the uterus may be due to the suppression of sexual impressions—as we see in the unmarried who have suffered from the shock of suddenly arrested love affairs where we have

reason to suppose that sexual feelings have been aroused and subsequently suppressed—in these cases, it may not be impossible, by due warnings, to aim somewhat at a prophylaxis of this condition.

#### INFLAMMATION OF THE OVARIES AND OVIDUCTS.

In considering the diseases of ovaries and oviducts, gonorrhœa claims our attention as being severe in its sequelæ, and in its onset being within reach of medicinal treatment. In the male gonorrhœa attracts early attention, and with men modesty is less a bar to the confession of its origin than with women, who often conceal the fact of an attack, partly from modesty, and partly with the view of screening, may be, an errant husband. They think the irritation of but little moment, or they wait, as in other diseases, in the forlorn hope that it will get better. But if we are consulted about a gonorrhœa in its early stage, every effort must be made to cut short the attack and bring it to a successful termination, as we know but too well how it may be propagated up through the uterine canal to the oviducts by the mucous membrane, or more directly by the lymphatics and so to the ovaries. When, however, the disease has reached the ovaries they become the seat of recurrent pain and inflammation, their normal function is interfered with, and, in the majority of cases, nothing remains but to hand over the case to the surgeon, their removal holding out the only prospect of permanent relief.

Where, however, ovaritis or salpingitis have their origin in chill or excessive coïtus, the precursor, it may be, of cystic enlargement, it is by no means hopeless to attempt a cure by treatment.

I had recently under my care a case where I was called in consultation, and found a tender, enlarged, and prolapsed ovary. Owing to the severe pain and manifest ill-health of the patient I advised its removal, and took the patient into an invalid home with that intent; but with care and

treatment, and the exhibition of the perchloride of mercury, and calomel occasionally, the symptoms quite subsided ; and examination failed to detect the ovary, which previously was plainly felt behind the cervix. We must not omit the consideration of the sexual element in all these cases, and where we suspect it as a factor in the production of tender ovaries we must prescribe physiological rest as well as other treatment.

#### TUBERCULOSIS.

Primary tuberculosis of the oviduct is occasionally met with, and before having recourse to surgical interference it is worth while considering whether general treatment with open-air exercise might not result in a cure.

#### SYPHILIS.

The sequelæ of syphilis scarcely lend themselves to surgical treatment, as we have but little evidence of syphilis leading to serious lesions of the intra-pelvic organs of generation. This disease, therefore, calls for early and prompt treatment by medicine.

#### CANCER.

I now come to that opprobrium of medicine, cancer. It is strange that after centuries of investigation, more or less scientific, we are nearly as far off, I was going to say, from the diagnosis, but at all events from the arrest and cure of this formidable disease. All operative interference with cancer is more or less bungling, *i.e.*, we lay down for ourselves a rule that where cancer is diagnosed the disease, as far as we can recognise it and it is accessible, should be removed. And what is the result? In the majority of cases the disease recurs either in the organ primarily affected and surgically interfered with, and in a small minority it is cured (?), *i.e.*, the patient has no recurrence, so-called, for many years, and is practically cured of that particular invasion ; or if a subsequent development of



the disease takes place, the question arises whether it may not be a separate and independent onset in a system already prone to the disease. In considering the question of cancer as invading the uterus and mamma, I will take the uterus first, and if my observations occasionally overlap, it must be taken as due in some measure to the intercurrent influence these organs have on each other.

There is no doubt but that some benignant and ordinary diseases of the uterus may be the precursors of malignant disease:—simple and protracted granular inflammation of the lips of the uterus, irritating applications used for the treatment of such condition, fissure of the cervix with eversion of the lips, followed by granular disease and induration, chronic endometritis and endocervicitis.

Physiological activity is, as a rule, opposed to pathological change. This is true in the main as regards the mamma, where we see that gland more frequently attacked by cancer in the virgin than in the woman who has borne children and suckled them. But with the uterus the converse seems true, as it is in the uterus that has often gone through the process of gestation with its subsequent involution that malignant disease is most frequently met with. When we come to the ovaries may it not be that the invasion of malignant disease, as *e.g.*, a sarcoma, is analogous to the formation of a dermoid cyst? *i.e.*, a perversion of its physiological function where impregnation has not taken place; or does it arise from lymphatic convection of deleterious matter from the uterus, or the consequence of a lowering of the vital energy of the organ from its disuse?

It is of the greatest importance that an early diagnosis of malignant disease should be made, but we are handicapped in our endeavours towards this end, not only by the unwillingness of patients to consult their medical man for what they consider a trifling discharge occurring probably at the approach of the menopause, some friend telling them that such an occurrence often ushers in the "change of

life," but also that medical men themselves too often disregard the early symptoms of cancer, and, neglecting to examine their patients, put them off with some placebo, telling them, if the pain or the discharge continues, to see them again, and so valuable time is lost, and when next the patient presents herself with more unmistakable symptoms it may be too late to render her any service.

Where intermenstrual bleeding occurs a patient should invariably be examined, as there must be some cause for it, and should it prove to be a polypus its removal will cure the malady, but should the examination reveal a state of things that gives even a suspicion of cancer, prompt treatment may arrest the development of a most serious disease. Coarse granular disease that bleeds too readily, or that extends into the cervical canal, should be treated, the former with the actual cautery or potassa caustica, the latter with free curetting and the application of iodised phenol. At the same time, a course of extract of thyroid should be given, and if, after a time, there is a suspicion that the disease is not yielding to "treatment," the case demands surgical treatment for the removal of the uterus.

In the case of the mamma we are more frequently consulted at an early stage of the disease, as the female mind is ever prone to dread the invasion of cancer, and patients will seek for advice at the least suspicion of a lump in the breast.

The mamma is subject to glandular enlargement not infrequently from its structural (*i.e.*, nervous) sympathy with the uterus, and where a patient presents herself with a more or less defined tumour or a diffuse thickening in the breast, the uterus should be carefully examined with the view of ascertaining if any morbid condition of that organ exists which might give rise to sympathetic enlargement of the mammary gland.

In some cases the successful treatment of inflammatory thickening of the uterus or its cervix may result in a subsidence of the mammary tumour. Again, the mamma is

often the seat of cystic disease seldom single, but a congeries of cysts appear usually at the base of the mamma, often extending for a considerable portion of its circumference.

If the pain is constant, or if the presence of such cysts is a cause of anxiety to the patient, it is better to remove the breast, as it not infrequently happens that such cysts degenerate into malignant disease, and we know of no remedy in medicine that will cause their dispersion.

When, however, a case is brought to us with a small lump in the breast, especially in a virgin, it will be advisable to give a guarded opinion, thoroughly to examine the uterus and ovaries, treat these organs if there is any deviation from a healthy condition, and at the same time put the patient on a course of thyroid extract.

In the married who have borne children the mammary gland may be the subject of inflammatory thickening either diffuse or more localised, this condition may yield to soothing applications, as belladonna with the exhibition of the perchloride of mercury, followed by or alternated with iodide of potassium.

When, however, a patient comes to us with a distinct lump in her breast with a history of a blow over the part, although some maintain that such accidents are often but coincidences, we should carefully bear in mind that the tissue subject to such changes of inflammation or the lowered vital energy which such an accident may cause, may possibly be obnoxious to the attack of some wandering malignant cell which it is not in a sufficiently healthy condition to throw off—such cell possibly having its origin in some morbid condition of the ovary, and, being conveyed by the lymphatics, finds its nidus in the sympathetic mamma. Such cases should not be lost sight of, but we should watch them carefully, and when we are convinced that the tumour is increasing in size, and especially if pain is present, no time should be lost in advising its removal; yet before it reaches that stage it might be advisable, until our knowledge is more complete on this subject, to exhibit thyroid extract.

There is a form of treatment of cancer of the mamma where the disease has advanced so far that extirpation of the tumour seems to hold out but feeble prospect of relief, that, though partly surgical, yet inasmuch as the surgical procedure does not aim at the direct removal of the disease, may, perhaps, legitimately come under the head of "treatment," *i.e.*, Dr. Beatson's suggestion to remove the ovaries and oviducts, and at the same time, give a course of thyroid extract.

These methods have been tried separately with no effect, but where the administration of the thyroid extract has been accompanied by removal of the appendages, several observers have reported very satisfactory results.

To illustrate the connection of the ovary and mamma, I may mention that last year I removed a sarcoma of the right ovary in a very advanced condition, and where there seemed but little prospect of the patient surviving, yet for a time she made a fair recovery. Some time afterwards a lump developed in the right mamma on its external aspect, and we thought it was a secondary deposit and had our fears as to its spreading. But, strange to say, after a time, perhaps synchronous with the arrest of the pelvic mischief, the tumour in the breast subsided. Subsequently as the pelvic mischief recurred the mammary tumour again became evident. With regard to the uterus and its condition of physiological activity in the process of gestation, parturition and involution, such involution may, by the frequency of pregnancy inducing a sluggish reaction, be interfered with, and the resulting sub-involution, giving rise to lowered vitality, or being in itself an indication of such inactivity, may prove the starting-point of cell proliferation, that, lacking sufficient healthy pabulum degenerates into the formation of pathological tissue. While such a serious disease as cancer is still among the arcana of our profession, any suggestions advanced should be carefully weighed and, where practicable, without risk to our patients, be acted upon. It is the natural dread of this fell disease that leads



patients to listen to the advice of any adventurer that holds out any prospect of relief, and so valuable time is often irretrievably lost. We should welcome, therefore, any contribution honestly and scientifically put forward by anyone competent to do so, as it is only by such patient investigation that we may hope some day to come into the possession of facts that may lead us to combat successfully a disease whose ravages are sadly on the increase. It is with this object that I would draw attention to a little pamphlet written by one of our Fellows on the "Pathogenesis and Treatment of Cancer," by Dr. Robert Bell, of Glasgow.

I am but too conscious that this paper is imperfect and fragmentary, but if it prove any contribution to the regulation of the gynæcological clock in preventing the pendulum of treatment swinging in one direction beyond the hope of recovery, the time spent on its consideration may not have been misspent.

MR. SKENE KEITH remarked that the Society was rather fond of ignoring the medical side of gynæcology, and the paper which they had just heard was a welcome change. But he thought Dr. Heywood Smith had made a mistake in compressing into a twenty-minutes' paper a subject which was so very wide. It was noticeable also that in the paper there was evidence of a continual hankering after surgery. On the other hand, on some points surgery was put too much in the background; for instance, in the case of early cancer of the cervix no "treatment" of any kind was admissible except removal, and the sooner this was done the better. The same remark applied to cancer of the breast. As regards the case mentioned in the paper, in which a sarcoma of the ovary was followed by a tumour in the breast, there was no evidence in this case that the breast tumour was sarcomatous; and it was a noteworthy point that after operations for sarcoma the patient often got quite well in nine months, and yet succumbed to the disease within thirteen months. Mr. Knowsley Thornton had come to this conclusion, and the late Dr. Thomas

Keith was in the habit of remarking the same thing. In conclusion, he would express the opinion that more medical papers were wanted by the Society.

Dr. C. H. F. ROUTH considered that gynæcologists of three types might be described, corresponding to the three political divisions of Conservatives, Moderates, and Radicals. If they met in consultation, one would say, "Do not operate under any circumstances;" the moderate man would say that the patient might go on all right for the present, but it would probably come to operation in the end; whilst the extreme radical held the view that if the patient was not operated on at once, she would certainly die. All three might be right on different occasions. Again, the question of operating often depended upon the circumstances of the patient. Some could not afford not to be operated upon; whilst a patient with means and leisure could often afford to wait, and even avoid operation altogether. The wishes of the patient as to the scope of the operation should also be taken into account. In illustration of the close sympathy that existed between the uterus and the mamma, he would mention three remarkable cases. The first was a  $\frac{3}{4}$  patient from whom he removed a breast, for cancer. She got on well for a week or two; then she started having little points like miliary seeds which developed round the wound. When these in no wise improved, but she rather grew worse, he said to her one day that he was sure that she had a disease of the womb. She protested that she had not. He urged that she ought to be examined, but she demurred. In the end she consented, and he then found that she had a large ulcer of the cervix. After he had treated this no more miliary nodules appeared, and it seemed to him probable that the taking on of malignant character by the original disease in the breast was due to the uterine disease. The second case was that of a married lady with very large bosoms; nothing that was suggested by way of treatment was of any avail. He then found that

she had an elongated cervix, which at the the end of twelve months had attained such a large size as to protrude six inches from the vulva, resembling the male organ. As this was a source of great inconvenience, both to her and to her husband, he took it off at its root. From this time the mammae began to shrink, and they soon returned to a normal size. The third case was also one of enormous mammae, which were so large that they rested on the patient's knees when she sat down. One weighed 11 lbs. and the other 9 lbs. Although she had five doctors in consultation, not one of them except himself would agree to remove the mammae. In this case also the patient had some uterine and vulvar disease.

Mr. BOWREMAN JESSETT said that the whole tone of the paper was one of caution and careful diagnosis, and this was precisely the line that all prudent surgeons would take. With regard to cancer of the breast, Dr. Heywood Smith had stated that it was more common in the single than in the married; he would like to know the source of Dr. Heywood Smith's information, for in his own experience at the Cancer Hospital just the reverse was the case. In dealing with a case of suspicious uterine hæmorrhage, he thought that the better plan was to remove a portion of tissue from the mucous membrane for microscopic examination. He agreed with Dr. Smith's remarks about cystic breasts; he had not found any treatment of much use, and his practice was to send the patient away to the sea-side, and, if after some months there was no improvement, the breast should be removed; especially because, as Dr. Heywood Smith said, it was often these cysts that degenerated into malignant disease. With regard to the treatment of inoperable mammary cancer by oöphorectomy and the administration of thyroid extract, he had adopted this plan in four or five cases; but in none of them was there any improvement. Even the principle of the treatment seemed at fault; for several years ago he had removed the ovaries from a patient; and that very morning he had

had to remove the breast for cancer. If the principle were correct, a patient ought not to develop mammary cancer after removal of the ovaries.

Dr. INGLIS PARSONS, referring to the subject of endometritis, said that they did not know much about its cause ; but there was one cause that he had observed, namely, prolapse of the uterus. It was very striking how the erosion and discharge often cleared up if the uterus could be kept up in place, for instance, with a pessary. For local application in these cases, he tried carbolic acid for three years, then iodised phenol for three years, and, lastly, linimentum iodi for a similar period ; and, in his opinion, there was no doubt that the last answered best. If endometritis persisted in spite of local applications and douching, then he curetted ; but sometimes curetting failed to cure it. On one occasion he saw a colleague pour iodised phenol into the uterus through a funnel, after curetting ; yet a week after the patient left hospital she returned with a yellow discharge as bad as ever. He therefore thought that it could not be due to a microbe. Menorrhagia was sometimes due to retroversion : in another class of case there appeared to be no organic cause for the menorrhagia, and even when curetting, no thickening of the endometrium was found. In such cases the prognosis was not good ; and some operators under these circumstances had resorted to hysterectomy. He had tried the constant current in these cases, with very good results. With regard to hysteropexy as a treatment for retroversion, he had observed that some surgeons practised the operation much more often than he had found it necessary to do ; in his experience most of these displacements could be remedied with pessaries.

Dr. HERBERT SNOW wished to protest against any "treatment" for tumours in the breast of women after middle age. This was also the time of life in which cysts occurred in the breast ; and in his experience such cysts always developed into cancer sooner or later. Dr. Heywood Smith had spoken of the "bungling" of cancer operations,



and bad results would always be the case as long as precious time was lost in "treating" new growths, whose real nature could almost always be recognised at sight, and as long as such confusion existed as was shown by the grouping together of cancer of the uterus and cancer of the breast. The former never caused marrow-infection; the latter always did; and a recognition of the fact involved some significant practical points. He agreed with Mr. Jessett that cancer of the breast occurred more often in the married than in the single.

Dr. HENRY JELLETT (Dublin) commented on Dr. Heywood Smith's statement that the prophylaxis of tuberculosis of the Fallopian tubes was fresh air; and asked, if this was so, how did Dr. Heywood Smith diagnose the condition? Did he first open the abdomen to make his diagnosis, and then use the fresh air cure? He also made the statement that tuberculosis of the tubes was very rare; yet the French school, who attribute the majority of suppurative affections of the adnexa to the gonococcus, admit that one out of every four cases of pyosalpinx is due to tubercle; the experience at the Rotunda Hospital confirmed the view of the frequency of tuberculous salpingitis.

Dr. MACNAUGHTON-JONES agreed with those who had said that such a paper as this, which gave rise to a discussion of a different type from those to which they were accustomed, was of peculiar value. If, however, Dr. Heywood Smith's object in bringing forward the different methods of treatment that he had adduced were to restrain the tendency to gynæcological operative procedure, it was evident that his paper could not be discussed in detail. They must content themselves with dealing with general principles. The entire path of advance of modern gynæcology was through pathological research, and on it, and it alone, treatment was founded and our means of alleviating the suffering of women secured. Only that treatment could be successful which had a pathological basis. Dr. Routh's analogy, drawn

from the political world of Conservatives and Radicals, was hardly applicable, for the so-called Radical gynæcologist was oftentimes the most Conservative, inasmuch as the operative measures he adopted saved the patient's life. Dr. Heywood Smith's remarks on uterine cancer surprised him, for in this, before all other conditions, tampering with the disease by palliative and expectant measures was to be deprecated, and it should, whenever possible, be actively dealt with in the precancerous stage. Early amputation of the cervix was preferable in this case to various applications and he had but little faith in thyroid extract. With regard to the breast, he altogether repudiated temporising with any kind of tumour or swelling. Whether it were a cyst, an adenoma, or other kind of growth, if it did not speedily yield to ordinary therapeutic measures, it had been his practice for the last twenty-five years to remove the growth. This did not involve sacrificing the gland. He did not by any means ignore the importance of treatment in Dr. Heywood Smith's acceptation of the term, and he had frequently dwelt on the importance of communications which were not of an operative character, and which would prove the value of such treatment. But they had to discriminate. Taking the case of the endometrium, for example, he felt sure that much of the tinkering treatment that was carried out, and the applications that were made, frequently did more harm than good. He had brought forward several cases of hæmorrhagic endometritis which had been under treatment for varying periods, cured by thorough and efficient curettage and the application subsequently of chromic acid. In conclusion, he maintained that true conservative treatment in gynæcology did not consist in temporising with disease by uncertain methods, but in adopting radical measures in every case in which the nature of the disease was such that no absolute cure could be looked for by palliative and expectant plans.

Dr. FRED EDGE (Wolverhampton) said that they all did best along the lines that they knew best, and not much good

was done by assuming that some men operated unjustifiably. No doubt some operated more than others; but surely most men used first the general means that were possible, and only resorted to severe methods when these proved to be necessary. He did not think there was any value in the treatment of mammary cancer by oöphorectomy and thyroid administration. He had performed the operation twice for this.

Dr. HEYWOOD SMITH, in reply, said that the case which he mentioned of a breast tumour following ovarian sarcoma was brought forward only to illustrate the sympathy between the two organs. Some of the speakers were mistaken in supposing that he advocated temporising in cases of malignant disease; on the contrary, he would in such cases always interfere at once. In his experience cancer of the breast was most common in virgins and in married women who had had no children; that is to say, it developed more readily in organs that had undergone no functional activity.

## ORIGINAL COMMUNICATIONS.

THE GYNÆCOLOGICAL TREATMENT OF THE INSANE.<sup>1</sup>

BY ERNEST HALL, M.D., L.R.C.P.Ed., F.B.G.S.

*Victoria, British Columbia.*

MY first attempt in gynæcological treatment of the insane was made on January 5, 1898, with such remarkable results that I have since lost no opportunity of investigation in this direction. Although the subsequent work has not yielded the success evinced by my first few cases, the later results have been fairly satisfactory, and sufficiently encouraging to justify my efforts and stimulate me to a more systematic and thorough investigation of the relations which exist between pathological conditions of the pelvic organs and abnormal psychic phenomena.

My examinations comprise 78 cases and my operations 33; I shall, however, confine my remarks to 42 examinations and 24 operations undertaken in British Columbia.

None of these patients presented indications of asymmetry of features. Neither amentia, high arched palate, irregular ears, defects of speech, deafness, chorea, strabismus, waverings of eyes nor twitching of facial muscles, were present. No trace of hereditary taint was obtainable in any of the cases operated upon.

The preliminary examination was at first conducted under anæsthesia, but latterly this was dispensed with when possible, and only used for violent cases. It has been

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<sup>1</sup> Presented at the Meeting of British Columbia Medical Association in Vancouver, August 9 and 10.



my practice to open the abdomen only when external examination revealed disease, but a more extended experience leads me to consider intra-abdominal examination essential, if there be indications pointing in that direction with an absence of determinable disease elsewhere. With modern methods such an examination should have no mortality and entail but a few weeks confinement, and surely a disease that would remove a patient from friends and society, perhaps for life, justifies such careful investigation.

*Results.*—Out of the forty-two cases examined in British Columbia, but two presented normal pelvic organs, these two were unmarried. Of the twenty-four placed under treatment twenty-two had been married. Of the married ones, nineteen had borne children, and the other three had salpingitic adhesions, giving evidence of former pelvic inflammation.

I report only such conditions as pathological, as in the opinion of the ablest authorities are recognised as capable of producing, in those whose mental powers are intact, local pain, discomfort, or general systematic disturbance. Perineal laceration was present in five cases, cervical laceration in six cases, retroversion with adhesions in seven, and simple retroversion in three cases. Adhesions of the clitoris were noted but once, while salpingitic and ovarian adhesions were found in ten cases. Cystic ovaries varying in size from a slight enlargement to that of a navel orange were found in eight cases, and a parovarian cyst in one case. Varicocele of the broad ligament plexus was found in four cases, and uterine fungoids in one. Far the greatest number of the lesions found were of the inflammatory class, next in order was cystic disease of the ovaries.

Of the mental results, I can report eight cured and two more nearly cured, two very much improved, three slightly improved, one improving; and have the satisfaction that, so far as I know, none have been rendered any worse by the treatment.

Of the physical results, all but two had normal convalescence from the operation ; one had suppuration in the wound, and one died eleven days after the operation, the *post mortem* showing acute cerebral congestion and a slight focus of suppuration at the seat of the ligature. One case died of basal meningitis nine weeks after the operation wound had healed and when the nurse had been discharged.

The duration of the insanity in those who recovered averaged about ten and a-half months, while in those who were not improved, it averaged twenty-four months. Of those whose insanity continued less than one year, with the exception of the deaths already referred to, all but one recovered. This is what we should expect ; it proves nothing, but suggests prompt action.

With a gradually increasing knowledge of pelvic pathology we realise that the sacrifice of normal tissue is by no means necessary. With modern methods, resection of cystic ovaries with retention of the healthy part is preferred to the sacrifice of the organ formerly practised. It is very rarely that the whole of both ovaries is removed. Nothing is more certain than that the removal of healthy organs does not in any way contribute to a restoration of the mental health. The pelvis in these cases must be subjected to the same treatment that would be given a patient whose mental condition was not in question. The disease and that only is to occupy the attention of the operator.

The post-operative treatment of these patients differs little from that of ordinary abdominal cases. Occasionally one may have to bind the patient to the bed, but in the vast majority, the nurse can control her actions with but little trouble. The selection of the nurse is a matter of extreme importance. She should be strong in mind and body, and possess sufficient tact to enable her to cope with, conquer, and dispel, the slightest indication to former abnormal habits of thought or expression. An additional nurse is required to take alternate duty.

These patients as a rule are anæmic. As soon as the

digestive system is in proper condition, they are placed upon an easily assimilated ferruginous tonic. Regular evacuations, and blood rich in hæmoglobin, are the best eliminators of the ptomaines with which, during years of impaired function and systemic depression, the tissues have been saturated.

The old proverb, *mens sana in corpore sano*, has long been recognised as expressive of normal health. But how close is the relation between the *mens* and the *corpus* it may be that few of us have yet even dreamed. Certain it is that as investigations into the physical realm are continued, startling facts are being constantly brought to light concerning the very intimate relation between the psychic and the physical. Is it not more than probable that we are just here treading the borderlands of a new world? Surely what we already know, though dimly, of the correspondence between the mental and the physical is sufficient to convince us that there are yet great discoveries to be made along that line. And let us not overlook the fact that the duty of jealous investigation in that direction belongs to the active practising physician. In fact he must be to the forefront in the scientific investigation of these problems.

Professor Foster tells us that "changes in what we call the body bring about changes in what we call the mind." Demonstration is not necessary to show that the sexual system, while in direct sympathetic connection with other organs, has also a unique connection with the psychical; nor to trace the relationship between a given psychological state and local pelvic congestion. The channel through which this relationship is made possible is that through which a local pelvic irritation may produce abnormal cerebral activity with disordered cortical function, giving rise to and indicated by abnormal mentality. These influences from peripheral irritations of the sexual organs may at times be inhibited by a strong mentality, but they may, if severe and persistent, eventually overcome the strongest subjective effort. Given a certain environment

of a strongly sexual character in a robust person, certain alterations of form and function follow, in response to such stimuli, in spite of effort of the will to the contrary. To obviate this result, the environment, or stimuli, which may be purely psychical, must be removed. Now if such stimuli, not necessarily objective, are sufficient to produce organic change in defiance of the will, so may a local pelvic irritation or stimulus, acting upon the higher nervous centres, cause abnormal psychical action, also in defiance of will power, ceasing only when the abnormal environment or peripheral irritation is removed. This is illustrated in the experience of my first patient, who, after recovering, gave me a somewhat detailed history of parts of her insane life, stating that she experienced and recognised within herself a force totally distinct from herself, which compelled her to speak and act directly against her better judgment. This force, formerly called "satanic," is but the unconquerable abnormal psychical reflex from a sensitive and diseased periphery, and the patient vacillates between reason and insanity, as the force is subservient to and dominated by the will, or becomes the ruling power in the organisation.

With this conception of insanity comes a new responsibility, especially to those who had formerly considered its development the limits of their medical jurisdiction. We must now consider insanity as merely the outcome of some serious physical lesion, demanding the utmost care and skill on the part of the medical attendant to discover, determine, and treat. At times such lesion may be easily found, but frequently and unfortunately it will elude his grasp. To consign a patient to an asylum without giving her the benefit of modern therapeutics, is unjust to her and cruel to her friends. To be sick may be unfortunate, but it is not necessarily a disgrace; neither can the occurrence of insanity in one member justify casting reflections on a whole family. So long as such erroneous conception exists in the public mind, we cannot be too careful



in this matter. To those on whom this affliction has fallen, and who live in perpetual dread lest through some mysterious visitation they also may become victims, we can bring hope, assuring them that the conception of "mental disease" as distinct from physical lesion, has passed away, that insanity is not the result of some vague demoniacal influence, nor the indication of disfavour upon the part of an offended Deity, but the direct result of physical disease, and only follows where physical degeneracy leads. And to our female patients worn by the burden of life's duties, and oppressed by its sorrows, harassed by the customs of Society and irritated by disease, whose mentality at times indicates the result of constant peripheral irritation, whose reflexes refuse to submit to subjective guidance and become temporarily dominant, and who reasonably look to us for relief, what shall we say? Is asylum life, with its unpleasant associations, its stone walls, iron bars, and uniformed keepers, calculated to restore jaded nerves, recuperate a wearied body and remove local disease? On the contrary, admitting the utmost kindness on the part of those in charge, is not such an environment comparatively as irritating to a sensitive nature, as her local disease is abnormal? When all other methods have been exhausted, and not until then, we may permit our patients to be removed to the care of the State. Let us look at this matter fairly, and, if necessary, in the concrete. In view of what has been accomplished in the modern treatment of mental disease, and in view of the true conception of insanity, how should we act with regard to our nearest relatives in times of affliction? Let us consider such symptoms as were formerly but finger-posts pointing to the asylum, as compulsory indications for closer examination and more skilful treatment. If such care were habitually exercised, the asylum commitments would be appreciably less; indeed, every case committed is a painful admission upon our part of inability to locate or remove physical disease.

No	Mental Condition	History of Physical Disease	Conditions found upon Physical Examination	Treatment	Results	
					Physical	Mental
1	Three years insane, at times violent mania	Absent ... ..	Cystic prolapsed and adherent ovaries	Double salpingo-ovariotomy	Perfect result, gain of thirty-five pounds	Recovered within eighteen days.
2	Melancholia for one and half years	Severe backache for six months	Ruptured perineum, varicocele of pelvic plexus	Curettag and double salpingo ovariectomy	Normal... ..	Improved.
3	Religious delusions for three years; also suicidal mania	Ovaritis fifteen years ago	Retroversion with dense adhesions	Removal of right appendage, freeing of adhesions, ventrofixation	Normal... ..	Recovered within twenty-one days.
6	Melancholia for two months, religious mania one month	Pelvic pain for four years	Adherent appendages, cystic ovaries	Double salpingo-ovariotomy	Recovered from operation; died from meningitis nine weeks after	Unimproved.
8	Hystero-mania; recurrent, one attack lasting six weeks	"Blood poison" following miscarriage	Perineal rupture, tubo-ovarian adhesion	Amputated cervix, removal of cystic ovary and ventrofixation	Normal... ..	Recovered.
11	Melancholia for one month	Absent ... ..	Perineal rupture, enlarged uterus with adhesions	Vaginal ovariectomy	Died	
13	Pre-menstrual mania, with delusions fifteen months	Absent ... ..	Pelvic varicocele adherent and cirrhotic ovaries	Double salpingo-ovariotomy	Normal... ..	Unimproved.
14	Delusions for three weeks...	Pain in back and side since last child	Retroversion with adhesions; salpingitis	Curetted, removed right and resected left ovary	Normal... ..	Recovered.
16	Mania and delusions, with melancholia one year	Caught cold after miscarriage	Ruptured perineum, prolapsed ovary	Amputated cervix, double salpingo-ovariotomy	Normal... ..	Unimproved.
17	Dementia of six years' duration	Absent ... ..	Cirrhotic ovaries with adhesions	Curetted, double salpingo-ovariotomy	Suppurating abdominal wound	Improved, but relapsed.
19	Mania with delusions two years	Absent ... ..	Retroversion with adhesions, ruptured cervix	Amputated cervix, curetted, removed right appendage and left tube	Normal... ..	Unimproved.
21	Melancholia of ten years' duration	Specific vaginitis...	Cystic ovary, retroversion with adhesions	Double ovariectomy	Normal... ..	Very much improved.

24	Melancholia, suicidal mania two years	Absent; "appendicitis"	Ruptured cervix, retroversion, adhesions, cystic ovary	Curetting, double salpingo-ovariotomy	Normal...	Recovered.
26	Melancholia with mania for two years	Pain for years, retroversion	Ovary enlarged ...	Curetting, trachelorrhaphy, double salpingo-ovariotomy	Normal...	Unimproved.
28	Melancholia with delusions for two years	Pelvic discomfort for years	Ruptured perineum, salpingitic adhesions	Removal of appendages...	Normal...	Unimproved.
63	Delusions with mania four years, and suicidal mania three weeks	Absent ...	Ruptured perineum and cervix, retroversion with adhesions; piles	Amputated cervix, ventrofixation	Normal...	Unimproved.
64	Melancholia and delusions four years	Absent ...	Adhesion of clitoris, retroversion, varicocele, fungoids	Curetting, ligation of veins, ventrofixation	Normal...	Unimproved.
65	Delusions, menstrual mania six years	Dysmenorrhœa and pelvic pain	Retroversion; cystic inflamed and adherent appendages	Curetting, removed right ovary and left appendage	Normal...	Recovered.
67	Mania with melancholia three months	Child-birth ...	Ruptured cervix ...	Curetting, trachelorrhaphy	Normal...	Slight improvement.
68	Delusions and mania three years	Absent ...	Ruptured cervix, ovarian cyst	Removed one ovary, resected other	Normal...	Slight improvement.
69	Delusions occurring occasionally	Pelvic pain, hæmorrhage	Enlarged uterus, endometritis	Vaginal hysterectomy ...	Normal...	Recovered.
73	Religious mania and delusions two years	Absent ...	Cervical polypus, retroversion, cystic ovaries	Curetting ovaries, ventrofixation, resection of ovaries, removal cervical polypus	Normal...	Unimproved.
77	Intermittent melancholia ...	Dysmenorrhœa and nervousness	Enlarged, prolapsed and adherent ovary, salpingitic adhesions	Removed right appendage, resected left ovary	Normal...	Recovered.
78	Mental confusion, inability to attend to household duties; melancholia intermittently	Pelvic pain for years	Retroversion with adhesions; varicocele, cystic and adherent ovary	Removed right appendage, resection of left ovary	Normal...	Improving.

Great as may be the satisfaction of reporting recovery after the removal of bodily disease, it is not to be compared to that experienced when we have also succeeded in restoring the mind. To remove physical ailments, and at the same time to "minister to minds diseased" is the highest ideal of surgery.

It has been urged that disease of the genital organs in women cannot be a prolific cause of insanity, because the ratio of male and female insane is about equal. Have the causes of insanity among the males been determined, and has it been shown that disease of these parts is not a factor in its production? Are not these organs, as to sex, undistinguishable in their embryological developments? Are not the nerve and blood supply analogous? Are not the ravages of disease in the parts recognised by well known lesions, and may there not yet be much to be learned in this particular field? Again, who are the men who largely recruit the asylum ranks? Are they not the young men who in the period of functional activity have excelled in abuse of their sexual system? We shut our eyes too often to the excessive waste of highly vitalised fluids, with its accompanying exhaustion, the inflammatory conditions, acute and chronic, which are the product of the gonococcus, to say nothing of the grosser pathological results—abscesses, strictures. Does nature bear all this outrage without revenge? Our asylum reports state self-abuse as a cause of insanity in a certain proportion of cases. An elongated and constricted prepuce, adhesions and retained secretions are a recognised cause of nervous disturbances in male children, and it is but reasonable to suppose that undue irritation and exhaustion may cause the most grave nervous disturbance in adults. When we have added to this condition one of specific infection, with all its train of results, it is within the limits of the probable that one cause of insanity in the male may be analogous to that in the female, and if so, it follows that the treatment should be as direct and radical.



Lest any careless reader or superficial observer, whose thoughts follow only beaten tracks, and whose memory hovers over "wholesale mutilation of helpless lunatics," and other absurd phrases, might conclude that it is within the meaning of this paper that the cause of insanity among women is found alone in diseased pelvic organs, or that surgical measures are advocated as a panacea for mental abnormality, I wish to emphasise that no such erroneous conception exists either upon the part of the writer or in the minds of those who have appeared before the public as workers in this department. What we do believe and shall always advocate is that the principles of surgery and humanity unite in demanding that the insane shall receive those measures of consideration and treatment that their diseases call for; that hapless sufferers from pelvic diseases shall have extended to them the benefits of modern treatment; and that our insane mothers, sisters and wives shall receive treatment equally skilful to that given in daily practice by our educated physicians.

*Conclusions.*—(1) That the prevalence of diseases of the pelvic organs, and the absence of any other determinable organic disease, in many patients who manifest psychic abnormality, coupled with the fact that in a by no means small percentage of cases the removal of the pelvic disease is followed by a rapid return to the normal mental condition, justly lead us to the conclusion that between pelvic diseases and mental aberration there exists some correlation, but as to its exact definition we cannot yet speak.

(2) That in all cases of mental abnormality in either sex which develops from the advent of puberty onwards, the condition of the pelvic organs, with their functions, should be made a matter of searching enquiry.

(3) That whenever possible before commitment to the hospital for the insane, the pelvic organs should be examined and if any abnormal condition be found, such condition should receive appropriate treatment.

(4) That gynæcological treatment should be recognised as a most important part of asylum therapeutics.

PREGNANCY COMPLICATED BY A FIBROID TUMOUR.  
THE HISTORY OF AN ILLNESS.

BY GEORGE E. KEITH, M.B.

IT seldom falls to the lot of any one to have such a succession of illnesses as I am about to relate, and the story of the months in the life of this patient may be of interest.

The patient was sent to my brother, Mr. Skene Keith, in January, 1898, when she was 41 years of age, with the view of being treated with electricity, as she had a fibroid tumour of the uterus. She was married and had never been pregnant; she did not look at all robust, and while the organs generally seemed to be healthy, the pulse was small and easily compressible. Some one had told her that the heart was not strong, but no evidence of any organic disease could be found. When the abdomen was examined, a hard, smooth and rounded tumour, decidedly prominent, was felt to extend up to the umbilicus; from below, the whole of the pelvis was felt to be full of the lower part of the tumour; the cervix could be reached at the back of the mass with some difficulty. As the tumour did not appear to affect the health in any way and as it was giving rise to no symptoms, no local treatment was recommended, but as she was a rheumatic subject some advice was given as to her health and mode of life generally.

On February 5, the patient was better; the tumour reached only to one inch below the umbilicus, though examined at the same time as before in relation to the period; the next period came a week late, and at the end of February the tumour was rather smaller than it had been at the beginning of the month; but on April 23 there had

been no period for eight weeks, and the tumour was slightly swollen.

On May 19, there was still no sign of the catamenia and the tumour was found to have increased to above the umbilicus. It was still very hard and except for the enlargement had not changed. The possibility of pregnancy, which had been becoming more and more likely, was now almost positively settled, and naturally the question of the chances of delivery had to be considered. The patient was advised to wait, as in Mr. Keith's experience such a mass of tumour, so long as it is not definitely growing from the cervix or the side of the uterus low down, gradually rises into the abdomen, leaving the pelvis free. A consultation was suggested by the patient, and, though not recommended to do so, she was told she might consult a well-known gynaecologist, who advised immediate operation as the only possible way out of the difficulty.

There were now two diametrically opposite opinions, one to wait, the other to operate, and it was advised that a third opinion should be taken and that the patient should then be guided by the advice of the majority, Mr. Keith making it clearly understood that, while he might advise the patient to take the opinion of the two, he would not promise to operate if he were in the minority. The third opinion, given after an examination under chloroform, was that the pelvic mass would probably rise out of the pelvis, and that, in any case, it would be safe to wait until the child was viable.

The patient was not seen from that time, the beginning of July, until the end of September, when it was found that the pelvis was quite free, and that there was nothing to prevent the passage of a child. Instead of filling the pelvis, the tumour was situated at the upper part of the uterus on the left, pressing up under the ribs. The patient was very miserable, she had never got over the dread left by the consultations as to what might happen, and passed most of her time in bed or in the garden until she came

back to town. There was constant nausea, dyspepsia and feeling of faintness, evidently due to pressure. Pain on coughing was very severe, the downward pressure of the diaphragm apparently irritating the mass of the tumour, and the ribs on the left side had to be fixed by strapping. As the days went on her misery increased, and it was impossible to comfort her by the assurance that her troubles would soon be over, as she had quite made up her mind that she was to die during her confinement.

Labour commenced on December 6, and lasted fifteen hours. The breech presented, and the child, a girl, was born without any trouble and without any tear of the perineum. The lady took chloroform well and there was firm contraction of the uterus and little hæmorrhage. When contracted, the upper part of the tumour was four inches above the umbilicus, and the mass on the left, gradually sinking down, was apparently so firmly fixed in the iliac fossa that it seemed certain the bowel must be compressed between it and the pelvic brim. There was no rise of pulse and temperature, and at the end of the first week it seemed that, at last, all her troubles were over.

On the 16th she felt uncomfortable, as the bowels had not moved for twenty-four hours, but as this had happened before I was not alarmed. A dose of castor oil was ordered, and the nurse was told to give an enema in the morning if necessary. When I saw her early the next day she had become alarmingly ill, the face was pinched and anxious, and nothing had passed from the anus. There was little distension of the abdomen, but much peristaltic action was going on from the right iliac spine in the direction of the colon round to the left. It seemed to be arrested where the mass of the tumour pressed against the brim of the pelvis. This peristaltic action was accompanied by what was described as "a terrible tearing pain." A hypodermic injection of morphia was given to stop this acute movement of the bowel, and under cover of it another large dose of castor oil was administered. Some hours later a long tube



was passed up into the bowel for nearly eighteen inches ; it seemed to get quite beyond the pelvic brim, and an enema of one pint and a half of soapsuds with an ounce of turpentine was injected. This was retained for twenty minutes, but when it came away nothing came with it. By the afternoon the abdomen was much distended and the patient was slowly losing ground. The pulse was slowly creeping up, and it became more evident every hour, that, if relief did not come soon, an unfavourable ending to the case was certain. By 6 p.m. the abdomen was more distended all over, the pulse had quickened to 116, and I sent a message to my brother to come and open the abdomen. When he saw her at eight o'clock, though no wind had passed down, the pulse had fallen to 106 and the abdomen was softer. It was decided to wait, though every preparation was made for immediate operation, and I slept in the patient's house. During the night a little wind passed, and in the early morning, after another high enema of soapsuds and turpentine, a great burst of wind went down. About noon the bowels moved very freely, the pulse fell to eighty, and the general condition of the patient rapidly improved. By Christmas-day the bowels were in their normal state, and though the patient was much pulled down there seemed no cause for further anxiety, except that, as the pelvic condition was much the same, the fear was always before me that the obstruction might recur. The greatest care was taken with the bowels, and the nurse had a standing order to give an enema any morning they had not moved by noon. As the patient gained strength slowly I kept her in bed long after the usual period, not allowing her to get up until January 10, the thirty-fifth day after the confinement. She was out in a bath chair on the 24th, and the air seemed to do her a great deal of good, so I began to congratulate myself that this tedious and, for a short time, alarming case would soon be done with. On the 27th, when I saw her in the morning, I told her that she had better not go out, as she had been very tired the day before

and as it was a dull morning. However, as the day improved and the sun came out, she did go out about twelve o'clock. She came in feeling so very cold and shivery that I was sent for. I found that she was complaining of pain in the right leg. It was swollen and tender, and it was evident that a phlegmasia dolens was developing. The limb was elevated, wrapped up in cotton wool, and the patient was told that she must keep very quiet. The swelling did not increase very much, not more than an inch and a half larger round than the other, there was no disturbance in the pulse, and only an elevation of one degree in the temperature, but it seemed to affect the general health more than was natural. On February 4, I was sent for very hurriedly between 1 and 2 p.m. On arrival I found the patient in a state of collapse, with sighing respirations, anxious pinched expression, bluey-white complexion, rapid feeble pulse, and with the fear of impending death. She was cold and presented every symptom of a clot having escaped into the general circulation. The nurse told me that about 1.30 the patient complained of a sharp pain in the right thigh, which seemed to pass all through her body to her chest; following this, all the symptoms alluded to commenced. I ordered hot-water bottles, stimulants, mustard leaf to the heart, and injected strychnia hypodermically, and gradually the acute symptoms passed away, leaving her terribly weak and shaken. As she was slowly recovering from the effects of this shock she complained, on the morning of the 6th, of a pain in the left side of the chest behind, especially on drawing a long breath, and, on examining the chest, a patch of pleurisy was discovered. By the next morning there was a considerable amount of effusion. Dr. Robson Roose and my brother saw her in consultation with me and advised immediate aspiration, as the heart was becoming embarrassed by the pressure of the pleural effusion. This was done, and ten ounces of a straw-coloured fluid removed. Dr. Roose further urged that if the fluid re-accumulated

the pleura should be opened and drained. On the 8th it seemed that the fluid was returning, and as this was very evident the next day, my brother, under chloroform, opened into the pleura, between the eighth and ninth ribs, and inserted a drainage tube.

At this time it hardly seemed possible to me that the patient could recover, she had gone through so much and was getting so tired of it all that now she did not seem to care, or to want to face the long convalescence that was before her. Had I known what was still in store for her, I am sure I would have given up all hope of her ultimate recovery.

On the 9th there was a nasty cough, and she complained of pain low down in the back; the face was flushed and the pulse and temperature were higher than the night before, the former being 98 and the latter 101-8°. On examining at the base of the lungs there was dulness at both bases, and there was no doubt that a double pneumonia had developed. One would have thought that this was to be the last straw, but on the 12th there were very distinct evidences of endocarditis, and on the same day the urine showed the presence of much albumen and granular casts.

How the patient lived through the next week it is quite beyond me to say. The only thing that did not go wrong was her stomach, which was usually her weak spot. Had it given out, she must have surely died. Every night when I went to bed (I slept in the patient's house that week) I expected to be roused to hear that her strength had given out and that all our fight was for nothing. It was with a heavy heart that I used to see her husband after each visit, for all the hope I could give him was that, as she had fought through so much she might fight on a little longer and possibly pull round.

Slowly these various diseases ran their course, and by the end of the month she seemed as if she would get well; she was emaciated to a degree and was so weak that the

least movement was a great effort; she was not very grateful to us for keeping her alive.

Everything went well until March 13, the ninety-seventh day after the confinement, when, in spite of all efforts, the bowels again became confined. Immediately she became desperately ill, the abdomen quickly distended, she vomited and the pulse rate rose. Next day she was at her worst; in spite of all our efforts nothing passed away from the bowel, and again the question of operation had to be faced. The condition was now very different to what it had been at the former attack; under the circumstances, and after the most careful consideration of the whole case, my brother and I agreed that the fight must be carried on with medicinal rather than by surgical means, that there was a chance if no operation was performed, and that the simple opening of the bowel to give relief, without even the slightest attempt at a radical cure, would be certainly fatal. This was explained exactly to the husband, and he was told that if there was no improvement during the night his wife would certainly die. He had little hope, neither had I. It was the most anxious night of the whole illness; no flatus passed until between 5 and 6 a.m., but after that it came away very rapidly, and by evening the obstruction was completely overcome. There was no further drawback, and I took the lady to Bournemouth at the end of April. She is now far better and can do much more than she could before the illness. She has her baby, and the tumour is decidedly smaller and is at present giving rise to no symptoms. Whether it will have to be removed later, time alone will show.



## REVIEWS.

DISEASES OF WOMEN : A HANDBOOK FOR STUDENTS AND PRACTITIONERS. By J. BLAND-SUTTON, F.R.C.S.Eng. Surgeon to the Chelsea Hospital for Women, Assistant Surgeon Middlesex Hospital, London, and ARTHUR E. GILES, M.D., B.Sc. Lond., F.R.C.S.Edin., Surgeon to Out-patients Chelsea Hospital for Women. Pp. 473, 115 illustrations. Cr. 8vo. Rebman, London. 1900. 11s. net.

Recent years have so enormously added in all directions, pathological, therapeutical, and clinical, to each subject a student is expected to master during the last years of his course of study, that it is absolutely necessary that he should be provided with a well digested and condensed text-book in each. There will ever be a large percentage of students, whose main object it is to satisfy examiners and successfully get through an examination. Even the addition of a fifth year of study does not enable the student before he qualifies, to gain anything like a special insight into the more highly specialised branches of surgery. For a more accurate study, and clinical as well as pathological investigation of the diseases of such parts as the genital organs of women, he has neither time nor opportunity. The observations recently made by Sir Michael Foster with regard to the experimental and analytical work done in our hospitals by the bed side, as well as in the hospital laboratory, must be re-echoed by every clinical teacher who has the thorough education of students at heart. For, as he remarked, there is too great a tendency to throw the burden of more accurate and special teaching, which should be given during his preparatory training, on the

post-graduate lecturer, and to encourage in the student the belief—one readily absorbed by the less industrious and least ambitious—that a comparatively superficial acquaintance with his profession is all that can be expected of him before he commences practice. However this may be, it is certain that there is gradually growing amongst students an idea that a superficial or sketchy knowledge, sufficient to satisfy an examiner, is all that is expected of the average student. There is always a minority in each school whose aim it is to proceed to the higher qualifications and cover a more thorough and extensive course, both of clinical work and reading, at least in some departments, before leaving their hospitals. To increase this number should be the aim of each member of a hospital staff, and every lecturer. But this division is inevitable, and therefore it is of the greatest importance that the work placed in the hands of a student for introduction to a given subject, should be of such a character as not only to give him such succinct and accurate information as is necessary for an examinational test, but also to stimulate him to a more exhaustive study and complete mastery of the subject. There is nothing worse for a student than the small cram book which is intended for a sort of question and answer summary of a subject. It is absolutely, from a scientific point of view, demoralising in the extreme.

Now the work before us is exactly the opposite to this latter type. It has stamped on it from beginning to end the clear evidence of personal research, and a painstaking selection of the most important pathological conditions bearing upon the clinical signs and symptoms of disorders of the female genitalia. Hence it has the true basis on which to start the student, and lay the foundation for his future practical success. The keynote of the book is struck in its brief preface. "It is a noteworthy fact that when surgical authors are able to restrain their vanity and refrain from publishing notes of successful cases in text books, the established facts of the art can be presented in a very con-

venient compass." And following this rule, with surpassing modesty, our authors have carefully hidden their lights under a bushel, and certainly given the condensed "milk of the word," from their own particular point of view, for the ready assimilation of their readers. We are all, even the most modest of us, open to the "pride that apes humility;" and an author has many ways of gratifying his vanity other than by the narration of his successful cases. Nothing is more helpful to an advanced student than the illustration of the application of methods and technique, by the carefully detailed and abbreviated notes, pathological and clinical, of a typical case, but there is a type of book in which such expansion is obviously out of place.

The authors have divided their handbook into 59 short chapters, among which there are distributed 115 figures, 28 of which are from original drawings by Dr. Giles, and 79 have been prepared under the personal superintendence of Mr. Bland-Sutton. It is sufficient only to mention this fact to guarantee the excellence of the pathological illustration it contains. If we might select any chapters for special commendation, it would be those which deal with uterine myomata, their pathology, the manner in which they imperil life, their relation to menstruation and pregnancy, and their clinical characters and treatment. It is satisfactory to find all through the work that the opinions of the authors are tersely and emphatically stated, and where modern views of treatment of a more radical nature are advocated, there is no hesitation in the advice that is given. Indeed, it is a feature of the work that the student is left in no doubt as to what the best line of practice the authors consider he should pursue is, in any particular affection. Possibly there is just a little too much of dogmatism throughout its pages, but perhaps this is not to be avoided in a manual in which the great object is condensation, though cut and dry axioms of diagnosis and treatment are not without their special dangers. Some chapters might,

even in a work for students, have been somewhat amplified, as, for example, that on "sarcoma, adenoma, and carcinoma of the uterus." Needless to say that those on diseases of the Fallopian tubes and ovaries are both original and, from the pathological point of view, among the most valuable in the book.

Altogether, it is a pleasure to take up a work of this kind and feel that it is to find its way into the hands of a student, inasmuch as though he may not gain from it as comprehensive a grasp of the subject as we might wish, it at least gives him, in a manner not surpassed by any other similar class book, an insight into a subject which has advanced with such leaps and strides within so short a period of time.

H. M.-J.

ANNUAL AND ANALYTICAL CYCLOPÆDIA OF PRACTICAL MEDICINE. BY CHARLES E. DE M. SAJOUS, M.D., &c., &c. Vol. v., Methyl-blue to Rabies, pp. 662, chromolithographs, engravings and maps. Large 8vo. Philadelphia : F. A. Davis & Co. 1900.

This work is probably well known and esteemed by our readers, and the present volume is quite equal in interest and in its excellent get-up to its predecessors. Among the articles more especially connected with gynæcology are "Metritis," by Byford, "Osteomalacia," by G. G. Davis, and, in obstetrics, an important essay on "Abnormal Parturition," by Grandin and Marx, one on the "Disorders of Pregnancy," by Currier, an article on "Pulmonary Circulation, including Atelectasis," with four illustrations of Dew's method of resuscitation, by the Editor, and a valuable contribution upon "Nursing and Artificial Feeding" by Emmet Holt and La Fetra. The literature of the years 1896-1898—and in some articles of 1899—has been included, and the book, both from its contents, its admirable printing and binding, will be a welcome addition to any library.



A SHORT PRACTICE OF GYNÆCOLOGY. By HENRY JELLETT, B.A., M.D., B.Ch., B.A.O. (Dublin University), F.R.C.P.I., L.M.; late Assistant Master Rotunda Hospital; University Examiner in Midwifery and Gynæcology, Dublin University. With 125 illustrations, pp. xiv. and 436; cr. 8vo. London: J. and A. Churchill, 1900. 7s. 6d.

Dr. Jellett's "Short Practice of Midwifery," the second edition of which appeared within two years of the first, has prepared for this book a welcome to which its own merits well entitle it. Like the former work, it is based upon the practice of the Rotunda Hospital, and the author's experience as teacher and examiner has enabled him, by omitting theories and procedures not yet generally accepted, to offer to the student and practitioner, in a work of moderate size, a comprehensive introduction to modern gynæcology.

In considering displacements, the author closely follows B. S. Schultze, reproducing many of his excellent diagrams, including the four illustrating the reposition of a retroversion.

An instructive diagram shows the various positions in which myomata may develop. For myomatous cases near the menopause Dr. Jellett thinks curetting or electrolysis particularly suitable. Oophorectomy need not be considered unless the nature of the tumour or the condition of the patient make hysterectomy impossible. If the growth does not reach above the umbilicus, vaginal hysterectomy with morcellation is the operation of choice, except in cases where vaginal enucleation can be properly preferred. Pan-hysterectomy is recommended in malignant growths of the corpus uteri and in tuberculosis. Of deciduoma malignum, the one ascertained fact is its connection with pregnancy. Altogether the tumours, innocent and malignant, are well described and discussed.

The first part of the book concludes with a chapter on intra- and extra-peritoneal hæmorrhage. We do not here find such an account of tubal pregnancy as might be

expected even in a manual, but Dr. Jellett has given a chapter in his "Midwifery" to this subject, which he considers an obstetrical rather than a gynæcological condition. The remainder of the book consists of descriptions of the major and minor operations of gynæcology, preceded by a short chapter on sepsis and the methods of sterilisation. Altogether the book is clear, concise, well written and well arranged, and is certainly one of the best manuals we have on its subject.

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*BRITISH GYNÆCOLOGICAL SOCIETY.*

THURSDAY, NOVEMBER 8, 1900.

H. MACNAUGHTON-JONES, M.D., IN THE CHAIR.

## SPECIMENS.

CASE OF HYSTERECTOMY FOR MYOMA UTERI AND BROAD  
LIGAMENT CYST. By CHARLES RYALL, F.R.C.S.,  
Surgeon to the Cancer Hospital; Surgeon to Out-  
Patients, London Lock Hospital; Surgeon to the  
Gordon Hospital for Fistula.

E. W., aged 40, was admitted into the Cancer Hospital  
in July, 1900, suffering from an abdominal tumour.

For many years she had noticed that the abdomen was  
enlarging, and two years ago her attention was drawn to  
a hard lump in the abdomen, which had gradually enlarged  
in size. One year ago she was laid up with an attack of  
severe abdominal pain, and since then she had had pain  
when walking about, in hypogastrium, over the sacrum and  
down the thighs, which was steadily getting worse and quite  
incapacitating her. The menstrual periods were excessive,  
lasting seven to eight days, with the passage of large clots.

She had been married three times, but had had no children and no miscarriages.

On examination she was found to be very anæmic, but otherwise a well-developed woman. Fixed in the pelvis was a hard nodular tumour of the uterus extending to midway between the pelvis and umbilicus, presenting a large smooth mass in Douglas' pouch, and apparently extending into the right broad ligament. Hysterectomy was indicated on account of the hæmorrhage, and also the pressure symptoms.

*Operation.*—The abdomen was opened in the median line above the pubes, and some extensive peritoneal adhesions had to be dealt with on the right side. The right broad ligament was then found to be the site of an intraligamentous cyst the size of a clenched fist. It was decided to first perform hysterectomy, which was done by first securing the vessels with forceps, dividing the uterus at the level of the internal os, and then ligating the vessels with silk. This left more space to deal with the broad ligament cyst, which was dissected out, and then the pelvic floor was completed as carefully as possible by suturing the peritoneum over the site of the cyst and over the cervical stump. There was still a good deal of oozing from the site of the adhesions, and from the damaged pelvic peritoneum, which necessitated drainage, and this was accomplished by making an opening through the pouch of Douglas into the vagina, and inserting a gauze drain. The abdominal wound was closed in three layers and dressed, and the vagina was loosely packed with gauze. The patient made an uninterrupted recovery.

In pelvic operations requiring drainage, my experience is that the more rational and infinitely more satisfactory method is through the pouch of Douglas into the vagina. Post-operative hernia is of such rare occurrence here, and as the pouch of Douglas is the most dependent part of the pelvic peritoneum, where any oozing is sure to accumulate, it can easily be removed by inserting a gauze drain.



Drainage through the abdominal wound would not only lay the patient open to the common risk of ventral hernia, but the gauze drain has to be inserted as far as the oozing surface, which is practically close to the site of ligatures, and these are apt to become infected with sepsis spreading backwards along the track of the drain, and thus leave the patient with a persistent sinus. I have never drained a case through the abdominal wound where I have not regretted it.

#### CASE OF MYOMA REMOVED BY MYO-HYSTERECTOMY.

By DR. MACNAUGHTON-JONES.

This case is interesting as bearing on the question which is now one probably of the most important in connection with the surgery of myomata, namely, the indications for operation. The tumour is comparatively small, about the size of a foetal head. The patient came a long distance for operation. Her surgeon accurately diagnosed the case, and placed before her three possible alternatives of treatment—either expectancy, in view of an early menopause, oöphorectomy or ligature of the uterine arteries, or hysterectomy. The tumour had distinctly enlarged during the five months which had elapsed from the time of its discovery. She had been curetted five years before, having suffered from membranous dysmenorrhœa for several years. She was a victim to asthma and dysentery. The most urgent symptom was inability to retain her urine. Seeing that the tumour was distinctly growing, and having regard to the general health of the patient, as also the effect on the bladder, together with the fact that her elder sister had died a few years previously of uterine cancer, I advised hysterectomy. The tumour proved to be a single solid myoma. It was removed by myo-hysterectomy, and recovery was perfect.

I am also enabled to relate a case in which I performed salpingo-oöphorectomy for bleeding myoma. This

is interesting because it bears on the question of oöphorectomy for bleeding myoma. The patient, a lady aged 42, who came under my observation a few years since, had been under treatment for several years, suffering from severe menorrhagia and metrorrhagia, with associated anæmia and consequent cardiac distress. She had had a few attacks of severe pelvic peritonitis, and there was more or less constant pain in the region of the ovaries. I found the uterus about the size of the closed fist, with a fibroid projection in the anterior wall. This accounted for the bladder irritation from which she suffered. I advised salpingo-oöphorectomy, which was agreed to. I did not raise the question of hysterectomy. The operation proved to be both difficult and tedious from the mass of adhesions in which the adnexa at both sides were embedded. I found the uterus studded all over with fibromatous projections, giving it a nodulated appearance, the principal nucleus being in the anterior wall. The following is the report of the condition of the adnexa furnished by Mr. Targett at the time :—

Both appendages show old inflammatory changes in connection with the tubes and broad ligaments. *The right tube* is closed at its ostium, the ampulla considerably dilated, and the uterine end appears thickened. There are many adhesions binding it to the ovary. The right ovary is small, skrunken, corrugated on the surface, but free of adhesions except towards the meso-salpinx. On section there are a few cysts, and one large corpus luteum.

*Left side.*—The mischief here is rather more extensive, in consequence of more adhesions between the tube and ovary. The tube also is more dilated, and its ostium blocked. The wall of the tube is not thickened as in pyosalpinx. The left ovary is flattened out and firmly adherent to the tube and meso-salpinx.

The operation was performed in the autumn of 1896, the patient recovered her health, lost her anæmia; there have been no pelvic symptoms, and when I last examined

the uterus it was considerably reduced in size. This affords a good example of a case in which salpingo-oöphorectomy successfully combated all the symptoms and saved the necessity for a future hysterectomy, but I must confess that I now consider the better procedure would have been to have done a myo-hysterectomy as well as the adnexal operation.

Dr. R. T. SMITH showed a specimen of degenerating fibromyoma with a large cystic cavity.

The SECRETARY read a report from the Clinical Research Association on Mr. Jessett's specimen of "Uterine Tumour" with probable degeneration, shown at the last meeting.

In the discussion on these specimens, Dr. PURCELL observed that at the time of Mr. Jessett's operation the question was raised as to whether panhysterectomy or supravaginal amputation should be done. As it turned out that the tumour was a sarcoma, panhysterectomy would certainly have been better.

Dr. HEYWOOD SMITH desired to again call the attention of the Fellows to the value of tincture of matico for arresting oozing from adhesion-sites. A large swab wrung out of the tincture should be firmly applied to the oozing surface for a few minutes.

Dr. HERBERT SNOW remarked that Howard Kelly, in his monumental work, laid down the rule that no drainage was necessary unless there was actual septic infection of the peritoneal cavity. They could generally rely on the peritoneum to deal with blood or effusions, or even with germs, unless these were very virulent. In laparotomy cases he had adopted the routine plan of leaving some saline solution in the peritoneal cavity, in order to dilute any poison that might be present; and the results had been very satisfactory. He asked whether Mr. Ryall had disinfected the vagina before inserting the vaginal drain, for if that were not done, they might get the very result they were most anxious to avoid.

Dr. ARTHUR GILES said that a cavity such as existed

in Dr. R. T. Smith's specimen might be a source of some perplexity. Some years ago, before hysterectomy became so generalised, he dilated the cervical canal in a case of fibromyoma with profuse hæmorrhage, in the hope of arresting the bleeding by curetting or by the removal of a polypus. In the course of the operation the dilator suddenly passed into a cavity, and a quantity of clear fluid escaped. For a moment he was afraid the bladder was injured, but further examination showed that he had tapped a cystic portion of the tumour lying behind the uterine cavity. The bladder was well out of the way in front. With regard to abdominal drainage, rubber tubes had been almost given up at the Chelsea Hospital for Women, and gauze was employed. When there was likely to be oozing, he regarded a strip of gauze as very valuable, not so much with the idea of arresting hæmorrhage, but to serve as an indicator if hæmorrhage took place. Otherwise a considerable hæmorrhage into the peritoneal cavity might take place before it was recognised. In general, he quite agreed with Mr. Ryall's objection to the use of drainage, except when it was unavoidable.

Dr. J. J. MACAN, referring to Dr. Giles' remarks about dilatation and curetting, said that Kossmann, of Berlin, had reported a case in which he performed curetting prior to colpotomy. The curette suddenly passed a distance of 13-14 c.m.; on doing colpotomy, he was able to satisfy himself that the uterine wall had not been perforated; and he attributed the deep passage of the curette to a temporary paralysis of the uterus, allowing of a considerable passive stretching of its walls. He thought that the question whether abdominal drainage should be entirely given up would form a good subject for discussion. On the Continent there was a growing tendency to rely on vaginal drainage.

Mr. RUTHERFORD MORISON (Newcastle-on-Tyne) thought that Mr. Ryall's plan of packing with gauze



and draining through the vagina was the best way of dealing with oozing adhesion-sites in the pelvis, and this was the plan that he employed himself. He had tried matico, but had not found it satisfactory. For hæmorrhage in the peritoneal cavity there were only two methods that were of any avail, namely, tying the vessels or gauze-pressure.

Dr. MACNAUGHTON-JONES referred to the indications for the operation of hysterectomy, which was still a matter of considerable discussion, and on which there was much difference of opinion, as shown at the recent meeting of the British Medical Association at which this point was discussed. Very little that was tangible or definite resulted from the opinions there expressed, inasmuch as extraneous matters were introduced, and the whole discussion was rather erratic. Since then he had had occasion to make an analysis of all the sources of danger to life which arise from the presence of a myoma. Classifying these, according as they were rare, not rare, exceptional, or common, and applying this division to degenerative changes in the tumour; adnexal complications; bowel complications; peritoneal complications; vesical, renal, and ureteral complications; circulatory complications; those arising from pregnancy; mental effects; and general consequences. Anyone who went to the trouble of analysing these dangers, and fairly computed the proportion in which such complications occurred, in every hundred cases of myoma not interfered with, would realise the fact that the old ideas with regard to the harmlessness of a large percentage of fibromatous tumours of the uterus were altogether wrong. Such a belief could only be accounted for by the fact that the termination of these cases was not as a rule recorded, and deaths occurred from direct and collateral issues of which no account was taken.

Mr. RYALL, in reply, said that he had tried tincture of matico; but he had found pressure and hot water

equally good, and he thought it a disadvantage to introduce an unnecessary foreign body into the peritoneal cavity. There were two reasons for removing any effused blood from the abdomen; first, that blood was a good culture medium, and no one could help contaminating the peritoneal cavity to some extent during an operation; and second, that effused blood formed a scaffolding in which connective tissue formed, leading to adhesions. The vagina in his case had been cleansed as thoroughly as possible before the drainage was used. In reference to Dr. Giles' remarks about the gauze drain, he had found such a drain difficult to remove unless wrapped round with gutta-percha tissue.

SOME NEW METHODS IN PELVIC OPERATIONS IN THE FEMALE. By J. RUTHERFORD MORISON, M.B., F.R.C.S., Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

I.—*Re-Section of the Sigmoid Flexure or Upper Portion of the Rectum.*

The sigmoid flexure of the colon possesses a special interest for pelvic surgeons. Suppuration of the left uterine appendages may involve it to such an extent as to demand its excision, or a cancerous growth invading its wall may lie at the bottom of Douglas' pouch, and is then not infrequently mistaken for an enlarged and diseased ovary.

An ordinary end-to-end anastomosis seldom succeeds when applied to the large intestine, and a lateral anastomosis is rarely possible in the conditions we are supposed to be dealing with. To overcome these difficulties and the still greater one of applying an efficient water-tight intestinal suture in the depths of the pelvis, I proposed and carried out four years ago the following operation, the steps of which are:—

(1) The diseased bowel is excised.

(2) A glass bobbin with india-rubber tube affixed is tied tightly into the upper end of the sigmoid flexure.



FIG. 1.—Excision of Sigmoid.



FIG. 2.

(3) The india-rubber tube is passed down from above through the lower cut end into the rectum, where it is aided to pass through the anus by the finger of an assistant. If there be any difficulty in effecting this, the assistant passes a stomach tube up from the anus into the belly. A piece of string is tied to the stomach tube and to the india rubber tube and all are drawn back through the anus.

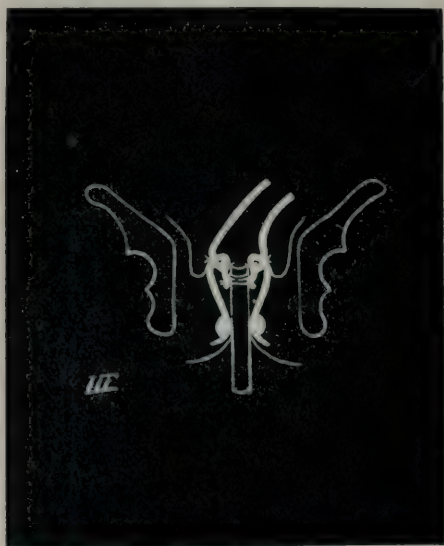


FIG. 3.

(4) The tube is drawn upon till the ligature on the upper cut end of bowel is inside of the lower cut end of bowel.

(5) A ligature is then passed round, immediately below the lower cut end, and tightly tied. This makes the junction watertight.

(6) The tube is again pulled upon, whilst the lower portion of bowel immediately below the button is steadied till, by traction from above, a short intussusception is produced. This is maintained by a few Lembert's sutures.



In from four to eight days the ligatured sloughing bowel separates, and the tube is then released. I have performed this operation fourteen times; twice for complicated pyosalpinx, in the remaining twelve cases for malignant disease. One of the inflammatory cases recovered and has had no subsequent trouble (three years); the other died. Six of the malignant cases recovered; six died. The percentage mortality is therefore high, but may be diminished by



FIG. 4.

avoiding the mistake I have made of performing this operation on cases of obstruction with loaded colon, for experience has taught me that in these cases the colon should be emptied by a preliminary colotomy before a radical operation is attempted.

## II.—*The Operative Treatment of Certain Forms of Parametric Abscess.*

For purposes of operative treatment, cases of pelvic cellulitis or lymphangitis due to septic infection after child-

birth and terminating in suppuration, may be divided into three classes.

(1) The floor of the broad ligament is involved. The abscess points towards the vagina.

(2) The cellular tissue of the broad ligament between its peritoneal folds is invaded. The abscess points above Poupart's ligament.



FIG. 5.—To illustrate Parametric Abscess.

(3) The lymphatic vessels and glands alongside the iliac vessels are infected, and the abscess is found high upon the back wall of the pelvis, or in relation to the psoas and iliacus muscles.

The operative treatment of the first two varieties is safe and easy. The abscess in the first case is opened from the vagina, and in the second above Poupart's ligament, and outside of, or through the peritoneum, which has become adherent to the anterior abdominal wall. It is to the third

form, in which a tumour is found high on the back wall of the pelvis or abdomen, and so the pus is out of reach from the vagina, that I wish to draw attention.

In December, 1893, I operated on two such cases by opening the abdomen. Realising the danger from septic contamination of the peritoneum, I packed carefully all round the swelling before the contained pus was allowed to escape, and mopped this up as it was discharged. A drainage tube was placed in the abscess cavity, the surroundings were cleansed as thoroughly as I knew how, the tube was packed round with gauze, and ample room was left for free drainage. It appeared to be impossible that any septic infection of the peritoneum could have occurred through the operation, but both patients died, the first five days, and the second, two days later; and a *post-mortem* examination showed virulent general septic peritonitis. I then devised the operation I now describe.

The abdomen is opened by an anterior incision three or four inches long, made in the middle third of a line drawn from the centre of the back of the ilio-costal space behind to one inch above the symphysis pubis in front. Through this incision the diagnosis is confirmed by palpation of the uterus, ovaries and tubes, and the relations of the abscess are ascertained. The incision is next prolonged to the back of the ilio-costal space through the external and internal oblique and transversalis muscles, leaving the fascia transversalis and peritoneum intact. Fair-sized branches of the circumflex iliac artery are divided here, and should be secured by torsion. The peritoneum and fascia are then held forward in hæmostatic forceps, and the left hand in the abdomen serves as a guide. The index finger of the right hand introduced posteriorly opens the abscess, by bluntly perforating the transversalis fascia under the thickest part of the swelling. A drainage tube, and iodoform gauze packing round it, complete this part of the operation. The entire wound is sutured in layers, except at the back where the gauze and drain protrude.

Since the calamities referred to, I have operated upon nearly twenty cases unapproachable by ordinary methods and in the manner described. All the patients have recovered.

III.—*Abdominal Hysterectomy, with a Note on a New Method of Securing the Uterine Arteries.*

Since my notes were completed, I have learned by reading the remarks of Mr. Harrison Cripps and Dr. Macnaughton-Jones, at a discussion of the Obstetrical

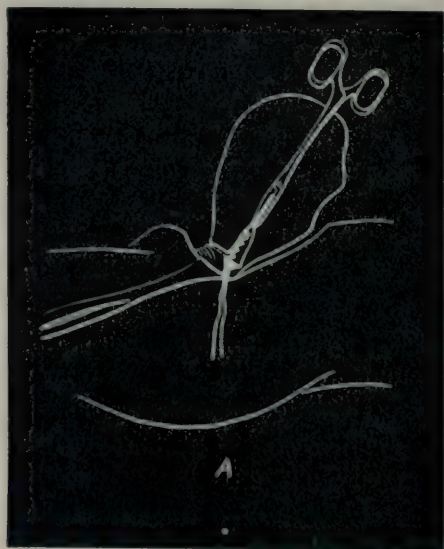


FIG. 6.

and Gynæcological Section of the British Medical Association, that the method I am about to describe is neither new nor peculiar to myself; but perhaps my remarks may serve to direct further attention to a simple and safe manner of performing the most difficult part of abdominal hysterectomy—the control of the uterine arteries.

The first stages of supra-vaginal hysterectomy are shown in fig. 6.



The ovarian vessels and the round ligament are ligatured below, the broad ligament is clamped above, and divided down to the side of the uterus. The peritoneum is divided transversely across the front of the uterus below.

In fig. 7 the transversely divided peritoneum has been pushed down from its uterine attachment and the uterine vessels may be seen. If not seen, a few short snips with



FIG. 7.

the scissors may make them evident, but if there is any difficulty, just as in Whitehead's method of excision of the tongue, they are divided first and caught after. Before cutting them, a clamp embracing the whole of the tissues, including the vessels, should be put on the divided broad ligament above up to the side of the uterus.

Fig. 8.—The stump left showing a forceps on the uterine artery, which has not yet been tied—two wedge-shaped uterine flaps, the posterior covered by peritoneum, the anterior bare—a loose fold of separated peritoneum in front.



FIG. 8.

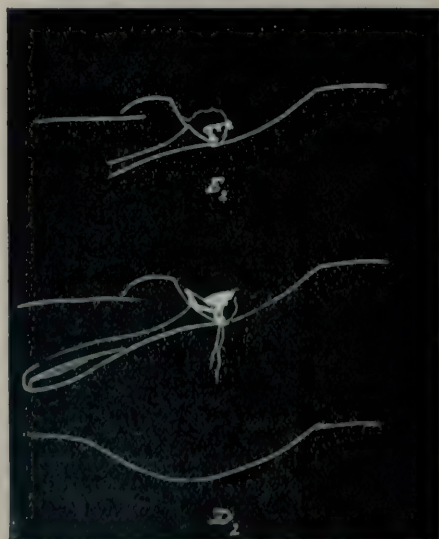


FIG. 10.

FIG. 9.

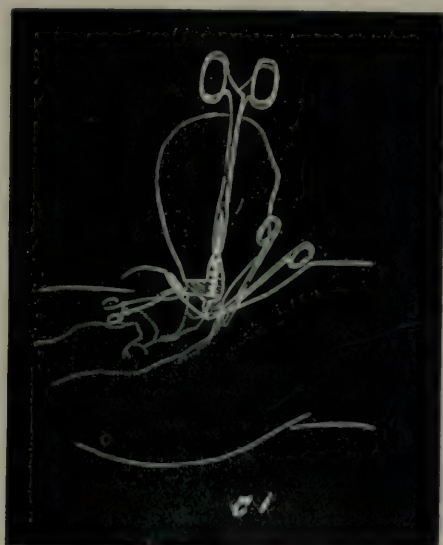


FIG. 11.

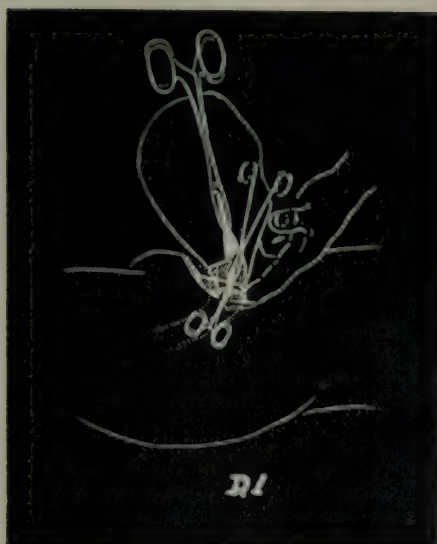


FIG. 12.

Fig. 9 (D2).—The arteries tied, the flaps sutured, the anterior peritoneal fold still unattached.

Fig. 10 (E2).—The stump buried in the anterior peritoneal flap.

When complete hysterectomy has to be done, the steps up to division of the uterine arteries are the same.

Fig. 11.—At this stage an assistant's finger in the vagina guides the operator's scissors from Douglas' pouch into the vagina behind the cervix.

Fig. 12.—The operator introduces his finger into the vagina from above, and, guided by this, snips the vagina with scissors all round close to the cervix, securing the uterine arteries when seen either intact or divided, and removes the whole uterus.

#### *IV.—Operation for Incontinence of Urine in the Female.*

A woman, aged 47, was admitted to the Royal Infirmary, Newcastle-upon-Tyne, on February 24, 1899. Five years ago she had an operation performed to fix her left kidney, and since that time she has had no power to retain or pass any of her urine, which constantly dribbles.

On admission to the infirmary she was found to be in the irritated filthy condition peculiar to long-continued urinary incontinence. Her urethra was patulous. The bladder was distensile and easily held a pint of fluid. The probable explanation of her condition was that it had resulted from a digital exploration of the bladder made at the time of the operation upon the kidney, but of this we neither sought for nor obtained direct information.

On February 28, 1899, I performed the following operation:—An incision one inch long was made in the middle line of the abdomen midway between the umbilicus and symphysis pubis down to the peritoneum. The patient was then placed in the lithotomy posture, and a circular incision was made round the orifice of the urethra. A second incision was made through the anterior



vaginal wall along the course of the urethra and for one inch on the base of the bladder. The urethra and neck of the bladder were then entirely separated, the tissue surrounding them being left attached and undamaged as far as possible. A pair of closed hæmostatic forceps was next passed down from the opening above the pubis close to the pubic symphysis and into the vagina. The end of the urethra was caught in the forceps, drawn upwards, and was attached to the skin of the incision in the abdominal



FIG 13.—Incontinence of Urine.

wall (fig. 13). The remainder of the incision was closed round the urethra, and an indiarubber catheter was tied in the bladder and projected from the anterior abdominal wall.

The dressing was left undisturbed for seven days, when it was found that the catheter had slipped out during the night. The dressings were quite dry, and the wound was healed. My house surgeon found the bladder distended, and drew off over a pint of urine.

The patient was discharged well on March 11, 1899.

The ultimate result has exceeded my anticipations, for

I only hoped to be able to make a continent bladder which could be readily emptied by the use of a catheter, but more than this has been gained.

I regret to say that owing to the mental peculiarities of the patient it is impossible to tell how much more, but this at least is certain, that the bladder will hold  $1\frac{1}{2}$  pints of urine against every effort to make it leak, such as coughing, straining, and alterations in posture, and that when the patient is in "good form" she can easily and entirely empty it by voluntary effort.

For the diagrams I am indebted to Mr. W. G. Richardson, F.R.C.S., Assistant-Surgeon, Royal Infirmary, Newcastle.

Dr. HERBERT SNOW asked Mr. Rutherford Morison in what respects his operation of resection of the sigmoid was superior to Kraske's operation. Moreover, was there not some risk of septicæmia from sloughing when the glass tube became separated?

Mr. SKENE KEITH thought that the bowel operation described by Mr. Morison was very ingenious; it would be very interesting to hear the later results of the six cases that recovered. He could not follow very well the steps of the second operation, as the diagram did not seem quite clear. In the account of the hysterectomy operation, with the possibility of having to open the vagina, there was a corroboration of the general view, that it was often impossible to tell what they were going to do until the operation was actually in progress.

Dr. P. Z. HEBERT called attention to an operation for incontinence which had been done on the Continent, and especially in Austria. It consisted in separating the urethra in the manner that Mr. Rutherford Morison had described; but instead of bringing the urethra up to the abdomen it was twisted through a half or three-quarters of a turn and then refixed in the same place. By this means the urethral longitudinal fibres assumed a cork-screw form, and the actual results had been found very satisfactory.

Dr. WM. TRAVERS said that in his experience the cause

of vesical incontinence was not infrequently the fact that the urethra was not only dilated, but pouched near the bladder ; in such cases separation of the urethra in the manner described by Mr. Morison would be very difficult. He had in several instances adopted with success the plan of removing a piece of the urethral wall.

Dr. HEYWOOD SMITH thought that great as was the discomfort of incontinence, it was not so great as would be that of an abdominal vesical orifice. In one case he had performed an operation on the lines indicated by Dr. Travers ; that is to say, he had removed a long wedge-shaped piece of the urethral wall, and the result had been very satisfactory.

Dr. E. A. NEATBY endorsed Mr. Morison's way of dealing with the uterine arteries. In performing pan-hysterectomy when, owing to malignant disease or other conditions of the cervix there was risk of soiling the peritoneal cavity, he had in some cases adopted the plan of drawing down the cervix itself and removing it by means of forceps introduced through the vagina.

Mr. CHARLES RYALL said that a cause of great difficulty in effecting anastomosis of the large bowel was the presence of large fæces, and he admired what he might describe as the "slim" way in which Mr. Rutherford Morison overcame this difficulty. He asked how the urethra acted when fixed to the abdominal wall ; was there a valve action of the parietes that prevented incontinence ?

Dr. R. H. HODGSON expressed the fear that the bladder operation as described by Mr. Rutherford Morison would lead to cystitis ; for it appeared doubtful whether the glass tube could empty the bladder completely, and there would be some residual urine, such as was found with enlarged prostate, that would tend to decomposition.

Dr. ARTHUR GILES said that, like Mr. Skene Keith, he had not followed the plan of making the incision in the operation which Mr. Morison had described for pelvic cellulitis. He asked how Mr. Morison effected the separa-

tion of the bladder in the panhysterectomy operation. Mr. Morison had described the opening of the pouch of Douglas and the passing of the operator's finger under the cervix ; did he then raise the cervix and separate the bladder from below upwards, as in Doyen's operation ? Or was this step of the operation carried out from above downwards from the abdominal side ?

Dr. MACNAUGHTON-JONES said that two of the operations were clear, those, namely, for pelvic cellulitis and for hysterectomy. With regard to the former, he would hesitate to make an incision that involved such an extensive dissection, for the less complicated such an operation was, the better. In two cases of pelvic abscess in which he operated in the usual manner the results were satisfactory. In the matter of securing the uterine arteries, he thought that the various methods proposed by Doyen were the ones that would last for the procuring of hæmostasis. Mr. Morison's operation for the resection of the sigmoid was new ; but it seemed to him that it would not require to be done often in the course of an operation for pyosalpinx. So also he thought that Mr. Morison's ingenious bladder operation would not find a very wide application. He had had a case of incontinence of urine due to the pressure of a fibroid in the anterior wall of the uterus ; he performed a ventrofixation, which had the effect of curing the incontinence.

Mr. RUTHERFORD MORISON, in reply, thanked the Fellows of the Society for their kind reception of his demonstration. He had been asked wherein his bowel operation was superior to Kraske's. He had pointed out that his operation was intended specially for cases in which the abdomen was opened, and in which either the sigmoid was infected or damaged by the proximity of a pyosalpinx, or a growth of the sigmoid had been mistaken for some other intra-pelvic tumour. But apart from this, he considered that the operation had advantages over Kraske's. As to the risk of septicæmia when the tube separated, Paul's tube had familiarised them with the mode of separation of a



glass tube in the bowel, and he had practically copied and adopted Paul's method. His operation for pelvic cellulitis was limited to those cases that followed childbirth, in which the suppuration was of a much more virulent character than was the case in other forms of pelvic suppuration. The latter kind could be safely opened through the abdomen. If pus from a puerperal case contaminated the peritoneum, the patient almost always died. The line of incision was a line passing from the ilio-costal space right round to the middle line. In the first instance, the abdomen was opened in the middle third only of this line; this was for purposes of diagnosis. If the case proved to be ovarian or the pus collection was far forward, it could be dealt with through this incision, prolonged forward if necessary; whilst if the diagnosis was confirmed, the superficial part of the incision was prolonged backwards, and the abscess opened extraperitoneally. The whole object of the operation was to keep pus out of the peritoneal cavity. He admitted that his method of securing the uterine arteries was not new, but he thought it was worth bringing forward all the same. There were disadvantages in the plan of passing a ligature round the uterine artery before cutting the uterus across; in the first place, a uterine vein might be pricked; and in the second place, the ureter was in danger. Gersuny's plan of twisting the urethra had already been tried and failed in the bladder case he described; in fact, the only difficulty in the operation was due to the cicatrices of the former procedure. No cystitis had followed this operation, and the result appeared to be entirely satisfactory.

**BRITISH GYNÆCOLOGICAL SOCIETY.**

THURSDAY, DECEMBER 13, 1900.

WM. J. SMYLY, M.D., PRESIDENT, IN THE CHAIR.

## SPECIMENS.

CASE OF TUBAL GESTATION ACCOMPANIED WITH PROFOUND COLLAPSE — CÆLIOTOMY — REMOVAL — RECOVERY. Under the care of F. BOWREMAN JESSETT, F.R.C.S., Surgeon to the Cancer Hospital, and Dr. BALGARNIE, Surgeon to the Fleet Cottage Hospital.

M. C., aged 32, married, two children, youngest three years, labours always normal. Periods regular until last, which she missed.

Dr. Balgarnie was called to see the patient on September 21, on account of a sudden attack of acute pain in the lower part of abdomen, accompanied by vomiting; she, however, continued to do her usual work until the 24th, when she had another attack of acute pain and sickness, accompanied by frequent faintings. She supposed herself to be nearly two months pregnant. On Dr. Balgarnie visiting her on the afternoon of September 24, he found her in a condition of profound collapse. She complained of great pain over lower part of abdomen and over the left clavicle, the latter being the more acute. There was no evidence of hæmorrhage, the pulse being very slow. Although a ruptured tubal pregnancy was suspected as a possible coincidence, examination *per vaginam* did not disclose anything further than a slightly enlarged uterus. Every means was taken to rouse the patient from the collapse, and the following day she was so much improved that it was deemed advisable to remove her to the Fleet Cottage

Hospital. For some days diffuse pain was experienced over the whole of the abdomen, and if any spot was more tender than another it was over the right iliac region. By rest and treatment the subjective symptoms gradually subsided, with an occasional interval of pain, which lasted about a couple of days. She had on two occasions slight loss of blood *per vaginam* simulating menstrual discharge; this lasted on each occasion about three days. About a fortnight after admission a small swelling was felt in the left broad ligament; this increased somewhat rapidly in size, and examination caused a good deal of pain. At this point Dr. Balgarnie asked Mr. Jessett to see the patient with him, and they agreed that it was a case of unmistakable tubal pregnancy, with rupture into the broad ligament, and localised peritonitis, with probable adhesion. As the patient was in a very feeble condition, and there was no evidence that further hæmorrhage was taking place, it was decided to delay operation for a week, with a view of getting her strength restored and so placing her in a better position to stand the shock of the operation. On November 8, with the kind assistance of Dr. Balgarnie, Mr. Wickham administering the anæsthetic, Mr. Jessett proceeded to operate. The patient being placed in the Trendelenburg position, the abdomen was opened in the middle line between the umbilicus and pubes; on exploring the tumour it was found to be somewhat firmly adherent to several coils of small intestine; these were carefully separated, as also were other adhesions in the pouch of Douglas; the tumour was then readily raised out of the wound and the broad ligament defined. This was transfixed with a double thread and securely ligatured. The tumour, which was about the size of a cocoa-nut, was cut away and the peritoneum carefully stitched over the stump, and the abdominal wound closed by two rows of sutures, one of silkworm gut going through the whole parietes, and the other of No. 1 silk securing the muscles and fascia.

The patient bore the operation fairly well, but was very collapsed later, the pulse sinking almost to vanishing point, and the respiration very shallow. A beef-tea and brandy enema was administered. Dr. Balgarnie saw her some few hours later and found her very collapsed, notwithstanding the injection hypodermically of strychnine. It was decided to have recourse to transfusion, and Dr. Balgarnie introduced 30 ounces of saline fluid into the median basilic vein. This had the effect of improving matters, and she speedily rallied; from this point an uneventful recovery took place, the stitches were removed on the tenth day, and the patient returned home on December 10 quite well.

Dr. HERBERT SNOW exhibited a pyo-nephrotic kidney, ruptured by the fall of a picture. The specimen had rather a medico-legal than a gynæcological interest; but was shown in illustration of a very common consequence of uterine cancer. The ureters eventually become blocked, and a condition of pyo- or hydro-nephrosis results, with death occasionally from uræmia. The patient was a woman, aged 47, with advanced uterine cervical carcinoma. When the accident happened she was lying on her right side, and the picture fell flatwise on her left flank. It was not a remarkably heavy one, and the distance only a few feet. In a healthy person no ill consequence would probably have followed. Here there was great pain, and after death in four days the pelvis of the left kidney was found to have been ruptured. The right exhibited a like condition, but in smaller degree, and, of course, without rupture.

Mr. FURNEAUX JORDAN showed specimens of (1) Carcinoma of the ovary, and (2) Tubal pregnancy, removed by vaginal cœliotomy.

(1) The first case was that of Mrs. A., aged 48, married thirty years; fourteen children, youngest aged  $4\frac{1}{2}$ . She had not seen anything for a year and eight months, after which she had more or less continuous hæmorrhage from the uterus for ten months before she came to seek advice.



When seen in April last she was very anæmic, and on examination there was found a round, tense, elastic tumour filling up Douglas' pouch, and rising well above the fundus of the uterus, which was pushed somewhat forward behind the pubes. Operation was undertaken on May 2, when by posterior vaginal cœliotomy what looked like a simple ovarian cyst was exposed. On tapping it the contents proved to consist of dark blood with a quantity of soft, brain-like tissue. The cyst had no adhesions, and was easily pulled into the vagina and its long thin pedicle ligatured.

On microscopical examination of the more solid portions the ovarian tissue was found to be replaced by a mass of carcinomatous cells; the few trabeculæ visible were found to have columnar cells arranged adjacent to them in a regular uniform layer, as if the columnar epithelium had invaded the ovarian tissue from the surface.

The patient recovered quickly, and was not seen after leaving hospital till, curiously enough, she came to the Birmingham Hospital for Women to-day. She has improved in appearance and has enjoyed good health up till a week ago, when she had a rather profuse hæmorrhage from the uterus. Bimanual examination did not reveal the cause of this. She will therefore be admitted for further examination.

(2) The second specimen was that of a tubal mole with an intra-peritoneal hæmatocele, which had been removed two weeks previously by posterior vaginal cœliotomy. The patient was an enormously stout woman. She had gone three weeks over her time, and was then seized with rather severe abdominal pain accompanied by irregular hæmorrhages from the uterus. This had continued for about ten days before examination. On examining her the pouch of Douglas was found to be occupied by a firm, tender mass, which projected more to the right than the left, but its exact upper limit could not be determined. The easy removal of the tubal pregnancy and the rapid convalescence of the patient show the advantages to be derived from adopting

the vaginal route when possible. In such a stout patient the abdominal route would have made the operation a difficult one.

Dr. P. Z. HEBERT showed a nine weeks' embryo in an intact amniotic sac.

In the discussion on these specimens,

Dr. HEYWOOD SMITH asked Mr. Furneaux Jordan what was the condition of the other ovary in his case of carcinoma at the time of the operation.

Dr. HERBERT SNOW thought that it would have been better to deal with the case of carcinoma of the ovary by abdominal cœliotomy; it would have allowed of a better examination of the condition of the other ovary and of the glands. With regard to the pathological condition, in his experience the most typical kind of columnar-celled carcinoma was to be found in the rectum, where the growth mimicked the structure of the glands. He preferred the term "cylindroma" for this condition. Such a growth seldom occurred unless some embryonic remnants were present, elsewhere than in the stomach and intestines.

Dr. J. A. MANSELL-MOULLIN did not think that the route of operation was of much importance as a rule; in Mr. Jordan's case, however, the vaginal route had marked advantages. He agreed with Mr. Jessett's view that all cases of extra-uterine gestation should be operated upon at once; for if undertaken early, operation consisted of little more than the flushing out of the hæmatocele. Too much reliance could not be placed upon absorption; for this process was slow, often occupying many weeks, and was associated with the formation of adhesions and fibrous bands. Moreover, the clot might become septic; and under these circumstances operation was nearly always fatal. Another reason for early operation was the difficulty of telling whether or not gestation was progressing. The tumour was formed before rupture took place, and the physical signs were due to the tumour and not to the rupture.

Professor JAPP SINCLAIR (Manchester) said that he

was under the impression that it was a generally accepted doctrine that the vaginal route was the best in cases of tubal pregnancy, other than the very acute cases. He did not think that these cases ever did well without operation. He mentioned two cases that occurred in one week in his practice. In the first, the patient had been ill for over twelve months, and had been curetted, etc. He thought she had tubo-ovarian disease, and operated through the vagina. As soon as the tumour was opened there was violent hæmorrhage; the opening in the pouch of Douglas was too small, and he had to rapidly extend it with scissors, and then drag down the mass. As soon as traction on the broad ligament was made the bleeding ceased. It was better, as a rule, in these cases, to tie off the broad ligament in sections, to avoid undue tension. Not much trouble was encountered from the adhesions in these cases, as they were mostly slight. In the second case, he profited by the previous experience, and made a larger opening to start with. There was very little bleeding.

The PRESIDENT said that they were all agreed as to the necessity of operation for extra-uterine gestation; none but a physician would think of not operating now, because there was no security for the patient as long as no operation was performed. His views about the operation route coincided with those of Professor Sinclair. With regard to the case of ovarian carcinoma, no doubt, if Mr. Furneaux Jordan had known at the time of operation the true nature of the tumour, he would have preferred the abdominal route, and have left the cyst unopened until after its removal, for fear of infection. He did not think that the vaginal presented any greater difficulties than the abdominal route in dealing with adhesions.

Mr. FURNEAUX JORDAN, in reply, said that in the first case he had examined the second ovary at the time of operation, and could then find nothing wrong with it. He agreed with the President that a malignant ovarian tumour could often be best dealt with through the abdomen.

But in this case the cyst so bulged into the vagina that, on puncturing, none of the contents reached the peritoneal cavity. It was possible that by this means there was less risk of infection than would have been the case if the abdominal route had been used. He was glad to hear the President say that all cases of tubal gestation should be operated upon. He saw one case that waited two years; and at the end of that time, although the patient had appeared to be in fairly good health in the interval, he opened an abscess with a macerated foetus. With regard to the dealing with adhesions through the vagina, he endorsed the remarks of the President. Blood clot usually peeled off very readily from intestine; and if it did not do so, no harm would result from leaving a part of the clot behind. He had not seen a case of direct rupture of a tube into the broad ligament. It seemed to him that some of the cases so described by Tait were really intraperitoneal.

Mr. BOWREMAN JESSETT was glad to hear from Mr. Furneaux Jordan that he considered the abdominal route to be the best for tubal gestation, except when there was a large hæmatocele in the pouch of Douglas. He believed that his own case was originally one of rupture into the broad ligament. With regard to Dr. Snow's case, it was not uncommon to find that death occurred in cases of cancer of the uterus, as the result of uræmia brought about by occlusion of the ureters by invasion or pressure of the growth.

#### SHORT NOTES OF FOUR ABDOMINAL CASES WITH COMMENTS. By GEORGE ELDER, M.D. (Nottingham).

My first case is that of a young married lady who consulted me at the beginning of this year, giving me the following history: Prior to her marriage, some eighteen months before, her health had in all respects been good; but within a few days of this event she began with heat and swelling of the genitals, painful urination, and yellowish



vaginal discharge; in fact, all the symptoms of an acute gonorrhœal infection. Ignorant of its nature, this state of things was allowed to go on for four months, much to the injury of her health, when an attack of pelvic inflammation confined her to bed, and caused medical attendance to be necessary. At the end of three weeks she was able to get up, and from then till her visit to me had gone about feeling very much out of sorts, troubled with a feeling of pelvic weight and discomfort, and a constant discharge. When I saw her she was thin, sallow, dyspeptic, and depressed with the long continuance of symptoms which not only were disagreeable in themselves, but also cut her off from the outdoor amusements to which she had always been accustomed.

On making a vaginal examination the uterus and its appendages were found much depressed, the former being retroverted and bound down, with the prolapsed and enlarged ovaries, in a mass of exudation in Douglas's pouch. A profuse yellow discharge exuded from the os uteri and bathed the vagina. The patient would not consent to operation, so treatment was at first directed towards relieving the discharge and the bearing-down symptoms by (1) rest in bed for six weeks; (2) the administration of pot. iod. in mixture and at night 5 grs. pil. hydrarg.; (3) applications to the endometrium of pure carbolic acid, supplemented by vaginal tampons of a saturated solution of iodoform and glycerine, changed every other day, after antiseptic douching. At the end of this time, there being a considerable improvement in her general condition and in the amount and quality of the discharge, she was allowed to get up and get about, in moderation, with the result that in a few days all the old symptoms returned to such an extent as to cause her to again take to bed and consent to an operation being done.

On making an abdominal section it was found very difficult to free the uterus and the ovaries and tubes from the mass of exudation in which they were imbedded. Both

ovaries were found enlarged, especially the left, and studded all over with enlarged cystic Graafian follicles ; the smaller of these were punctured, whilst one on the left side, as large as a walnut, was resected and the incision stitched up with fine catgut. The tubes were found thickened and impervious, so the outer two-thirds were removed and the stumps used for slinging up the uterus, by stitching them to the transversalis fascia.

As there was very considerable oozing from the pelvic floor, a drainage tube was used for a couple of days. The patient made a very good recovery, and went home at the end of four weeks, with her uterus in good position and altogether relieved of her symptoms. It is now over six months since the operation, and in a letter received from her last week she states that she is perfectly well and menstruates regularly.

There are several points in this case which seem to me worthy of consideration. The first is, the cause and the questions it involves. Everything points to its venereal character, and I cannot but think that the husband must have believed himself perfectly safe to marry. That a gleet discharge is capable, under certain conditions, of setting up, especially in the virgin, the state of things which was found in this case, is not I think sufficiently appreciated by the laity.

It is the bounden duty of the family medical man to whom these cases in the first instance go, to tell the whole truth about the danger they involve their wives in, if they prematurely get married.

With regard to the destructive and far-reaching consequences of gonorrhœal infection to the female it is needless to speak at this Society ; they are too well-known to us.

Coming now to the operation itself, I have no hesitation in saying that a few years ago the uterine appendages, in the state they were found, would have been ruthlessly removed, but now fortunately with wider experience, and

a more enlightened pathology, every endeavour ought to be made to conserve some ovarian tissue for the sake of its influence upon the future health and happiness of the woman, and only remove what is hopelessly diseased. That this method has been successful in this case is borne out by the result. A curious light is also thrown upon the different theories of menstruation by the fact that although the tubes are withdrawn from the mechanism of the function, it goes on regularly and naturally as before.

My second case is that of Miss W—, aged 55, whom I saw with Dr. Illiffe, of Derby, on July 15. She was a thin, pale woman, who had always had good health until two and a-half years ago, when troublesome irritation of the bladder caused Dr. Illiffe to be called in. The urine was examined several times and found normal, and after a few days' treatment the illness passed off and she regained her usual good health until July 8 of this year, when she was suddenly seized with severe abdominal pains, faintness, and sickness, for which Dr. Illiffe was again summoned. There supervened a smart attack of peritonitis, and it was whilst she was recovering from this that I saw her with Dr. Illiffe. She complained very much of severe backache, which had interfered with her sleep, and this, coupled with stomachic irritability, had contributed to wasting considerably her normally thin body, so that as she lay on her back, with the abdomen exposed, the tumour, which had been previously discovered by Dr. Illiffe, was plainly visible as a prominent loculated growth occupying the lower half of the abdomen and running up into both lumbar regions, especially the left. Examination of it, by palpation, was somewhat difficult on account of the tenderness which still existed, but enough was done to discover that we had to do with a thick-walled multi-cystic tumour. Vaginal examination showed that the growth filled up the pelvic cavity and the uterus could, with difficulty, be felt high up in front. A tentative diagnosis of twisted ovarian pedicle was given, and operation advised as soon as she had recovered from

the attack. Two days afterwards she was taken by road to my private hospital, and on July 24 an abdominal section was performed. I may say that during the week she was with me before operation, the urine was examined several times, as is my custom, and found to be absolutely normal both as regards quantity and quality.

On making the abdominal incision, the tumour presented itself and was tapped; quite three pints of dark, bloody fluid, free from smell, being removed. With the reduction of its size, it was seen to be retroperitoneal in position. The peritoneal incision was lengthened upwards and downwards, and enucleation of the tumour effected, and it was only towards the end of this that its renal origin was revealed. The tumour had so encroached upon the retroperitoneal tissue that it seemed to carry the greater part of the abdominal and pelvic viscera on its surface.

As above said, the freeing of the tumour was a very difficult matter, and also very tedious, and had to be suspended several times on account of the critical condition of the patient, which was combated by repeated hypodermic injections of strychnia, and enemata of brandy and hot water. The right kidney was the one involved, and before closing the abdominal incision, I felt the left kidney and the uterus and ovaries to be normal. Although there was a large amount of bared surface, pressure by sponges had been so unremittingly kept up as the operation went on, that at its termination there was no oozing requiring drainage. Beyond laying together the cut edges of the peritoneal investing sac, nothing was done in the way of suturing, chiefly because the patient was suffering so intensely from shock, and time was of supreme importance.

For several days the patient's life hung in the balance, and after this period, for quite a month, her progress towards recovery was very slow, varied with occasional relapses, which made me somewhat doubtful of her ultimate recovery. Eventually these unfavourable symptoms passed off, and her convalescence became assured, so that she was



able to return home perfectly well on September 18, her departure being delayed a week longer than was necessary on account of her relations, with whom she lived, being away from home.

In considering this case the question of the diagnosis is the one which naturally first presents itself. Barring the slight illness of two and a-half years ago, there was nothing in the history of the case pointing to its true origin, and the nature of the seizure which she had in July certainly, in conjunction with the physical signs, favoured the notion that one had to do with an ovarian twisted pedicle; an opinion which, even after the evacuation of its contents, seemed to be borne out by the appearance of the fluid, which was quite typical of that which is found under such conditions. That a renal tumour could so disturb the relations of the abdominal contents without interference with the general health is to me a revelation, and can only, I think, be explained upon the hypothesis that until the date of the seizure its rate of progress had been so slow and gradual that the parts had time to accommodate themselves to the altered condition. Evidently a sudden outpouring of blood brought about the alarming conditions preceding the discovery.

My third case is that of Mrs. S., aged 55 (but looking much older), who first consulted me three years ago, suffering from a subperitoneal fibroid tumour attached to the lower posterior surface of the uterine body.

At that time it seemed about the size of a foetal head, and now and again it had caused what the patient described as inflammation pains. It was after one of these attacks that the fact that she had a tumour was discovered. Menstruation, which had always been scanty, ceased at forty-five, and she married two years afterwards. As there were no urgent symptoms an expectant treatment was advised. Until the autumn of 1899 her health kept good, and the growth gave but little trouble. It then seemed to become more active and caused frequently recurring and severe pressure pains,

also increasing trouble with the bowels and irritation of the bladder. Operation was then advised, but rejected by the patient, and nothing was seen of her until the beginning of this last August, when her sufferings had become so great that she was thankful for something to be done. On making a vaginal examination it was found that the tumour almost completely blocked up the pelvic outlet. The patient's general condition was considerably worse than it had been twelve months before. On August 27, with the patient in the Trendelenburg position, abdominal section was performed. On opening the abdomen, it was found that the tumour had pushed up the posterior reflection of the peritoneal covering of the uterus, and had also burrowed into the connective tissue of the recto-vaginal septum. Lying on its anterior surface was the very small senile uterus, to the lower part of which it was attached. A long incision was made over the growth, and its enucleation effected with considerable difficulty, as it had wedged itself into the pelvic cavity. To facilitate drainage from the large bared surface, the uterus was removed at the vaginal junction and a strip of gauze passed through. The operation was then completed by suturing the abdominal wall. (The tumour, which weighed  $2\frac{1}{2}$  lbs., is here shown.)

The convalescence of the patient was quite satisfactory, barring a little cystitis which occurred during the second week, owing to the use of the catheter for a week, but this soon passed off. On October 1, barely five weeks after the operation, the patient, who had been up several days, returned home.

The sequel of the case was disappointing, inasmuch as after a week's stay at home, apparently all right, she was seized suddenly one night with pain over the right kidney, rise of temperature, sickness, quickened pulse and somewhat scanty, bloody urine. Dr. Corcoran, of Loughboro', her usual medical attendant, was called in, and put her on a rigidly milk diet, and did what was necessary to relieve her symptoms by local and constitutional remedies.

Four days afterwards, when I saw her with him, the symptoms had somewhat improved, the urine was free from blood, and the temperature and pulse ratio had decreased. There was evidently some localised peritonitis over the right kidney, but no enlargement of it or fluctuation could be felt.

Examination of the abdominal and vaginal cicatrices gave negative results. Evidently the patient was suffering from inflammatory mischief affecting the right kidney, but as she and her friends were opposed to any further operative measures, the line of treatment which had been adopted by Dr. Corcoran was continued. Nothing further was heard of the case for nearly four weeks, when we received the announcement of her death. The following letter from Dr. Corcoran, in answer to one of mine, completes as far as one can, the record of the case :—

Loughboro', Nov. 26, 1900.

Dear Dr. Elder,—Mrs. S—— continued very much as you saw her, except that the pain of the right kidney diminished; for nearly three weeks the symptoms resembled enteric, when dulness became manifest over the right kidney, followed by deep fluctuation. I pointed out to Mr. S—— the possibility of operative procedure, but the patient was then so ill that I did not urge the matter, especially as both patient and friends were very averse to the idea.—Yours faithfully,

T. CORCORAN.

From the contents of the above letter, there can be but little doubt that the patient died from septicæmia, following upon nephritis or perinephritic suppuration, and the origin of this, in the absence of a *post-mortem* examination, can only be matter for conjecture. The patient's urine was examined several times before the operation and found normal, and remained so except during the short time when she had cystitis. For the three days prior to the operation

the quantity of urine passed in the twenty-four hours was respectively 20,  $76\frac{1}{2}$ , and 63 ounces, whilst for the seven days following, it was 14,  $23\frac{1}{2}$ , 29,  $27\frac{1}{2}$ , 51, 77, and 63 ounces. For the first four days the patient was mainly fed by nutrient suppositories, having nothing by mouth excepting small sips of brandy and water for the first two and a-half days, her thirst being relieved by rectal injections of Oj water twice a day.

From the end of the first week until she went home the quantity of urine passed was sufficient, so that I think one may fairly put out as a possible cause of death, the question of injury to one of the ureters. There was nothing either in the pulse or temperature differing from normal convalescence. The temperature never rose above  $99\cdot2$ , and only on the second, third and fourth days did the pulse rise above 100.

It seems to me that the cause of death lies between the lighting up of a slowly progressive renal degeneration, the result of long-continued pressure by the tumour upon the ureters, which an ordinary examination of the urine could not discover, or else that a septic focus had been left in the connective tissue of the pelvis from which the peri-renal infection had spread.

The only remaining points of interest about the case are:—(1) The time at which the tumour first gave trouble, some seven years after the menstrual function had ceased; and (2) the relatively more serious import a tumour has when wedged into the pelvic cavity, than a much larger growth in any other position.

The fourth case is that of Mrs. S——, a patient of Dr. Allen, of Belper, whose ovaries and uterus I removed in 1894 for papillomata.

She had been tapped previously twelve times, and on refilling for the thirteenth time, an operation which was commenced for exploration ended by removal of the growths, which I now show. The whole pelvic cavity was filled with a mass of papillomatous growth, and there were



numerous warty excrescences on the visceral and parietal peritoneum.

My reason for again bringing the case before the Society (having previously done so in 1894) is that the patient not only made a perfect recovery, but remained well and free from any recurrence until the end of last year, when she was lost sight of.

No one can be more sensible than I am of the fragmentary and imperfect character of these notes, but they will have served their purpose if they furnish grounds for what I hope will be an interesting and instructive discussion.

Mr. BOWREMAN JESSETT said that Dr. Elder's second case was very like one that he had himself reported before the Society some weeks ago. (See *BRIT. GYN. JOURN.*, November, 1900, p. 218.) The third case was very interesting, and found a parallel in a case reported by Dr. Purcell. (See *BRIT. GYN. JOURN.*, August, 1898, p. 174.)

Mr. CHARLES RYALL asked why Dr. Elder, in his first case, had given iodide of potassium and blue pill, and used glycerine and iodoform as a local application. It seemed to him to be a case in which the gonococcus had infected all the genital canal; and they knew now that the proper treatment in gonorrhœa was the local application of strong remedies, such as nitrate of silver, 40 grs. to the ounce; or, in extreme cases, pure carbolic. It was very difficult to know how to advise men who had had gonorrhœa, especially those with a chronic gleet; it had been proved over and over again that the disease might lurk, not only in the anterior urethra, but also in the posterior urethra and Cowper's glands, and might infect a woman after all outward signs of the disease had disappeared. With regard to Dr. Elder's third case, he pointed out that it was a very rare thing for peritonitis to occur in cases of pyonephrosis; neither were the symptoms present, nor were adhesions and other signs of peritonitis found at the operation.

Mr. SKENE KEITH said that the interesting points about

the kidney case were, first, that the tumour extended into the pelvis; and second, that the greater part of the swelling was on the side opposite to that to which the kidney belonged. With regard to the case of hysterectomy, he had seen a case of his father's which presented some similarity. The patient did well for the first few days after operation, except that she was very flushed and almost cyanotic. She died some weeks after getting home, and a *post mortem* showed that there was hardly any kidney substance left.

Dr. JOHN SHAW, in speaking of the first case, said that although the symptoms and sequelæ seemed very like gonorrhœa, he had seen cases of salpingitis, especially of hydrosalpinx, on one or both sides in young women, as a result of excessive sexual intercourse. Such a condition usually got quite well under hygienic treatment. The second case reminded him of his first ovariectomy, performed under the guidance of Dr. Mansell Moullin. She did well except that for some time she could not pass water naturally, and the catheter had to be used. After a few weeks he heard that she was "passing water naturally." It really meant that she did not need the catheter, but she passed very little urine, and suffered much from strangury. After a few weeks she died of kidney trouble. At the *post mortem* the mucous membrane of the bladder was found to have been injured by the catheter, there being a perforation in the mucous membrane, round which a deposit of phosphates had formed. The kidneys had apparently become infected from the bladder. He suggested that perhaps some such infection would explain Dr. Elder's case.

Dr. JAPP SINCLAIR said that ten or twelve years ago he had a case of papilloma of both ovaries. He was under the impression at the time that the condition was a malignant one; but he saw the patient in the early part of last year, and she appeared to be quite well. In another case the pelvis was so overgrown with papillomatous masses as to resemble a bird's nest; but the patient made a good

recovery, and although this was five or six years ago, she had continued quite well.

Dr. ELDER, in reply, said that his treatment of gonorrhœa, when there was no tubal disease, was to dilate the cervix and apply pure carbolic to the endometrium; this was repeated if necessary. He gave iodide of potassium and mercury mainly because this treatment had been recommended by Mr. Taylor in such cases, in the paper which he read before the Society. With reference to Dr. Shaw's remarks, he thought there must be very few Fellows of the Society who had seen hydrosalpinx develop as the result of sexual excess; his own experience was that hydrosalpinx and pyosalpinx were always due either to gonorrhœa or to puerperal infection. Dr. Shaw's explanation of the bladder case would not hold, because his nurses always used a very short glass catheter, not long enough to injure the bladder wall. The case of papilloma which he had related, and some other similar cases, had given him the idea that papilloma was not a malignant condition; but in some other cases there had been rapid recurrence and death. There were probably therefore variations in the malignancy of this kind of growth.

ON CIRCULATORY PHENOMENA AS SEQUELÆ OF THE PREGNANT UTERUS. By R. HUGH HODGSON, M.D. Vice-President, British Gynæcological Society.

Of the many theories advanced as to the cause of labour at full term, none, so far as I am aware, attach sufficient importance to the blood supply.

Let me quote a few of the theories recorded.

(1) "That the over-distended condition of the uterus, occurring at full term, induces labour."

We are not told why the uterus is over-distended, nor why it ceases to grow sufficiently to prevent over-distension, nor how nor why the over-distension induces labour. Over-distension is more likely to paralyse muscular contraction.

(2) "That at full term separation of the placenta takes place owing to fatty degeneration of the decidua. In consequence of this the ovum acts as a foreign body and brings on uterine contractions."

But why does fatty degeneration of the decidua take place, and why does it select a particular time for so doing? and further, why does the ovum, floating in its own liquor amnii and still receiving blood through the placenta, act as a foreign body through the decidua?

(3) "That the onset of labour at the tenth month is due to congestion occurring at a menstrual epoch."

Why not the eleventh, or twelfth, or any other epoch?

(4) "That the foetus at full term has the power of exciting uterine contraction."

If, for argument's sake, we admit that the foetus is the cause of labour, then we must admit that it causes labour not only at full term, but also at other periods of uterine gestation, and if it be capable of inducing labour at, say, seven months, why should it not at times lack that power until, say, twelve months?

(5) "That ovarian excitement is the law of parturition in all its forms of ova expulsion."

Why are the ovaries excited to that exact pitch necessary to cause labour precisely at nine months? Why not twelve months? And what about labour when the ovaries, having been removed months before delivery, are soaking in pickle jars?

The most intelligible reason for the setting-in of labour appears to me to be the failure of nature to maintain the balance between the rate of growth of the pregnant uterus and its contents, the foetus and the liquor amnii. For my purpose it is sufficient to say that approximately the uterus, at the moment of conception, weighs two ounces, and at full term about twelve times that amount; and that it is capable of holding one ounce of fluid at the time of conception, and no less than 150 ounces at full term. In other words, the uterus increases twelve times in weight, and its contents 150 times.



The importance of this disproportionate increase I hope to demonstrate.

The rule that all cystic bodies, when their nutrition is cut off, lose some of their contents either by evaporation or absorption is well provided for in the uterus, which, having a superficial and a deep layer of lymphatics, can afford to suffer interference with its deep layer, since its superficial is, by virtue of its position, almost free from pressure from within.

During the first three months of pregnancy we observe that immediately upon the successful attack of an ovum by a spermatozoon, that ovum undergoes remarkable changes, and at once proceeds to provide for itself means of future nutrition by creating villi with the object of first drawing supplies from the secretion poured out by the now hyperæmic Fallopian tube, and then for its three months' succour from the decidua.

With the entry of the ovum into the uterus we find that organ prepared for its reception, its walls hypertrophied and charged with blood, its mucous membrane much thickened, and its subepithelial tissue extremely vascular. The ovum, with its villi fully developed, finds a bed in the mucous membrane, draws its nourishment therefrom and dismisses its vesicle to the relics of the past.

As time advances and pressure commences to be exerted by the ovum and the liquor amnii upon the decidua reflexa through the decidua vera and the uterine walls, the supply of nutrition to the chorionic villi generally decreases, and the villi in consequence dwindle away except in that situation where the ovum deems it advisable to lay down vessels of a larger and more permanent nature.

At the end of three months, however, the intrauterine growth has filled the uterine cavity, the decidua vera and decidua reflexa have come into contact, and the subepithelial circulation, enormously increased since conception took place, experiencing difficulty from pressure, threatens to bring about abortion by reducing the blood

supply to the chorionic villi. This is the greatest crisis in intrauterine life, or the time when abortion is most likely to happen.

Coincidentally, however, with the lessening of the sub-epithelial blood supply to the circum-placental site, we find that the formation of the placenta is proceeding apace with its blood supply derived directly from the arteries in the muscular wall of the uterus.

At the end of the next three or four months the pressure which has been steadily increasing has caused union of the decidua vera and decidua reflexa, and has almost obliterated the branching vessels which interlace with the muscular fibres of the uterus. We should here remember that it is in the innermost layers of the middle coat of the uterus that the new muscular fibres are principally formed, that it is in that layer also that we find most of the small inter-lacing arteries which supply both it and the decidua, and that in pressure upon that layer may we look for the cause of the arrest of growth in bulk of the uterus at about the sixth month of pregnancy. With this arrest of growth it becomes necessary that those fibres already in existence should be subjected to gradual stretching in order to meet the continual expansion of the intrauterine growth, which is thereby again imperilled by the chance of having its blood supply reduced. Should the uterus tolerate this change, then a second and lesser crisis in foetal life is passed, and all goes well until the persistent intrauterine growth pressing upon the confines of the placental site curtails its nutrition. The superficial lymphatics, the vessels least disturbed, continuing to absorb whilst the liquor amnii is less abundantly secreted, cause relaxation of the uterine walls, and "dropping of the womb" results. "Dropping of the womb" appears to be a real descent, and a sign of pregnancy having passed through all its phases normally, and it is brought about by the diminished tension upon the uterine walls allowing that organ to adapt itself to the pelvis.

When we consider the anatomical distribution of the cervical branches of the uterine artery, how they encircle the cervix, and how much they must be stretched by the rapid growth of the pregnant uterus and the spreading out of the cervix over the membranes, it will, I think, occur to most of us that they must become so attenuated that they fail to afford the necessary nutrition to the cervix which it demands in its endeavour to withstand the great physical strain put upon it, which is out of all proportion to that falling upon any other part of the organ. The result of this decreasing blood supply is the weakening of the part.

The upper zones being relieved of some of their strain contract, the cervix, which is the weakest part, both by its starved blood supply and over-stretching in addition to the weakness consequent upon its central aperture, dilates under the tension, and thus labour is initiated. The temporary decrease in the intrauterine pressure is followed by a temporary increase of blood to the uterine walls, and this increased nutrition of both muscular and nerve fibres is the stimulus to contraction.

In support of the theory that the reduction of the quantity of liquor amnii in the uterine cavity induces contraction of that organ, I would draw attention to the various means adopted to procure premature birth. To wit, rupture of the membranes with escape of liquor amnii is followed by contraction. Ergot, by reducing the flow of blood to the uterus, lessens the liquor amnii. Continuous stimulation by the introduction of a catheter produces a like result.

Thus I suggest that labour is in reality initiated by the gradual lessening of the blood supply to the placenta at least a week before the advent of those symptoms described in text-books as the commencement of labour.

The contention that the blood supply of the cervix is the first to be reduced is supported by the law of gravitation, the fact that the cervix towards the end of pregnancy is found to be less engorged with blood and considerably

thinner than it was only a short time before, and further, that in rupture of the uterus the cervix is the first part to give way, which would not be the case if it continued to receive its accustomed blood supply, for the cervix of the non-pregnant is the strongest part of the uterus.

Against the argument that the blood supply determines when labour shall set in, may be advanced cases of premature birth which take place before either the cervix or the body of the uterus have been subjected to sufficient pressure to interfere with their blood supply.

It is not possible here to enter into all causes of premature birth, but it is sufficient to point out that what is sufficient to produce premature expulsion is sufficient to alter the blood supply. For instance, shock may cause premature birth, and shock may certainly alter the blood supply. Further, it may be urged that since the liquor amnii varies in quantity in different cases, so should the time for the setting-in of labour. There certainly is a tendency to miscarriage in cases of excessive secretion of amniotic fluid, but as the water is secreted from the amnion, it follows that an increase of water necessarily indicates an increased supply of blood to the amnion, and an abnormal blood supply points to a loss of tone of the uterine muscular tissue, which condition presupposes that the uterine wall nutrition has been defective through the poor quality of the blood, and that the wall in such circumstances is susceptible to excessive expansion before its fibres become taut. Whether the alteration be in quantity or quality the ultimate result is the same—namely, diminished liquor amnii preceding the expulsive efforts of the uterus—although it appears to be more those circumstances in which the blood constituents are perniciously altered in which early birth may result, than those which simply tend to increase or decrease the quantity of blood; hence it is that operations upon the parts need not, whilst fevers generally do, cause expulsion of the foetus.



In the death of a foetus by strangulation by the cord round its neck we have an instance of congestion of the placenta arising on the foetal side. In the assertion that the uterus and ovaries become congested at the approach of each would-be menstrual period, and that premature birth is prone to happen about that time, we have an instance of the congestion occurring on the parental side. In both cases, however, the result is the same, namely, expulsion of the foetus. In medicine and surgery congestion is a passive hyperæmia of a part with reduced pace of circulation and a tendency to coagulation. The placental site of the uterus being its thickest part, and containing the sinuses into which the chorionic villi dip, is the part in which we would expect the greatest amount of congestion and the growth of the foetus and liquor amnii to be arrested.

In hydramnios, the walls being over distended, the muscular tissue is slow to contract, and hence the first stage of labour is tedious. Withdrawal of but a small quantity of liquor amnii is followed by contraction. We may well ask, if the theory of the intrauterine pressure being the cause of labour be correct, how is it that with this excessive amount of distension the placental site has not been starved of its blood supply? Our knowledge of the cause of hydramnios amounts to simply the suggestions that it may be due to inflammation of the amnion, or, perhaps, disease of the foetus. Bearing in mind that nearly all the children are born dead and prematurely, I am inclined to think that the death and subsequent expulsion are due to the starvation of the placenta by pressure of fluid, and that that starvation is not brought about earlier either by some alteration in the uterine walls or arteries whereby the vessels are not compressed at the proper time, or else that the placenta, having fixed upon a part of the uterine wall opposite to where its vessels enter, receives its blood supply directly from them, without their having first traversed more than the thickness of the wall.

Why an extrauterine foetation at full term should be accompanied by labour pains is answered, I think, by the application of the principle of the relative growth of a cyst and its contents, inasmuch as the temporary uterus, for as such we must look upon the cyst containing the extrauterine foetus, experiencing the controlling effect of its contents upon its walls, cuts off the placental nutrition, whilst absorption taking place an attempt at revival of circulation is made, and the stimulus thereby imparted is conveyed to the uterus by the intimate association of the nerves which abound in the situation.

I have endeavoured to show that following the rule which pertains to the more rapid growth of the contents of a cyst than its wall, is due the increasing pressure upon the uterine walls in the latter days of pregnancy, which, shutting off the blood supply to the placenta, causes its disintegration and separation. If we accept the foregoing theory as the normal process, and allow that involution actually commences before those symptoms we call labour, it is easy to understand what little disturbance may produce not only birth of the foetus before term, but also the most common of all the diseases likely to follow pregnancy, namely, subinvolution. By this theory of supply and demand we can conceive how it is that abortion or miscarriage is more likely to be followed by subinvolution than is labour at full term. In the latter case Nature has struck her balance, and involution has been provided for. In early deliveries the uterus in its plethora and in the height of its hyperplastic activity is suddenly called upon to take unto itself a degenerative process, with the result that in many cases, being unequal to the task, new tissue remains. Believing that healthy opposition to oneself, even in one's own argument, is conducive to the elucidation of the truth, I have brought forward instances, both in health and disease, which at first sight appear to militate strongly against the theory that interference with the blood supply determines when

expulsive efforts should be made by the uterus to expel its contents.

In considering subinvolution it is advisable to recognise two distinct phases of the same disease.

For convenience I have called them the large and small cavity varieties respectively. The large cavity, due to many pregnancies, general debility, exhaustion following tedious labour, reduction of the blood supply of the uterus by overstimulation of the sympathetic as in prolonged lactation, or to disproportion of blood constituents as in anæmia, in Bright's disease, and in the debility of late marriages. In this variety of subinvolution we have a starved organ, with muscular fibre unable to give that support so essential to the control of its blood supply, and in addition the walls of the vessels themselves are flaccid. Not only may the blood be at fault in quantity or kind, or both, but it may contain a substance detrimental to nerve energy. The sequence of these faults is menorrhagia and metrorrhagia of longer and more persistent nature than in the other form of subinvolution which I will presently describe. The automatic cessation of this flow is, I suggest, brought about by the over dilatation of the vessels or rather relaxation of their walls, the loss of their recoil producing slowing of the stream; and the reduced quantity of blood failing to fill the vessels, stagnation ensues, and finally completely obliterates their lumen. The foregoing process of arrest of this particular kind of hæmorrhage differs materially from that produced by the introduction of hot water. For the arrest by water appears to be due to the action of heat encouraging an increased flow of blood from the parts beyond the depleted organ, with the result that the hæmorrhage is arrested by the natural process. This suggests the reason why cold water so frequently fails to arrest the hæmorrhage—cold water acting as a whip to an exhausted horse, and hot water as food. A good illustration of this is found in post-partum hæmorrhage.

In the small cavity variety of subinvolution we have the very reverse condition of the uterus, an overfed organ,

excess of muscular tissue, and close support of well-nourished vessels, with consequent spasmodic attacks of hæmorrhage due to collections of coagulated blood in its cavity. This condition of the uterus may be attributed to delivery before six months advance in pregnancy, abortion, arrest of menstruation by shock, cold, fever, or what not, when by the too early removal of the cause which necessitated the hyperplasia, or by interference with the subsidence of the hyperæmic state, we contribute to the retention of an excess of blood over and above that required to replace waste, and thereby lay the foundation of an addition to the muscular fibre of the uterus. That a uterus in such circumstances should bleed abnormally calls for the explanation that the uterus which is least stretched naturally has least need to contract, and the earlier in the growth of the ovum the more apparent is the disproportionate increase of the uterine walls—the reverse of that which holds good with the advance of pregnancy. Therefore, the earlier the expulsion of the foetus the more the liability to disproportionate subinvolution.

Since to errors in the blood supply both forms of subinvolution are due, to the circulation must we look for their cure. By drugs we may alter the character of the blood, and by the same means we may decrease or increase its quantity. In the curette we have a valuable aid to the cure of this form of subinvolution.

The two forms of subinvolution compared :—

<i>In one we have</i>	<i>In the other</i>
<b>Large cavity.</b>	<b>Small cavity.</b>
Thin, flaccid, ill-nourished walls.	Thick, well-toned, highly vascular walls.
Capillaries prone to break down, and slow to regenerate.	Capillaries slow to break down, and quick to regenerate.
Fairly constant hæmorrhage.	Spasmodic hæmorrhage.
Requiring increased vascular supply for its cure.	Demanding depletion for its cure.

In no part of the human body is there so manifest an exhibition of the wonderful provision of Nature to protect herself from injury as there is in the pregnant



uterus. Nature recognising the enormity of the change that the uterus must experience during the growth of the foetus, and being desirous of avoiding injury therefrom, places the main arterial trunks in the outermost layers of the muscular coat and the superficial lymphatics directly under the peritoneum, where they both escape with but little interference. She also strengthens the walls of the veins outside the placental site, and in order that the mucous coat and innermost layers of the muscular coat, which have to bear the brunt of the disturbance, may be equal to the calls made upon them, she pours in an excess of blood and lays down new temporary fibres. The subsequent disappearance of these fibres, the re-opening of the small vessels closed by pressure and the renewed activity of the deep lymphatics is the work of involution.

#### TO EPITOMISE.

From the moment conception takes place a race commences between the uterus and the ovum. The uterus becomes rapidly active, its walls charged with blood; with wonderful celerity it lays down muscular tissue, and even its mucous membrane swells with pride at having captured a live ovum.

The ovum, at first an insignificant being in the uterine cavity, gradually develops and threatens the uterine walls, recognising which the uterus hastens on with both its development and expansion until the end of six months, when, finding that its competitor in the race having won the inside of the circle is pressing forcibly upon its food supply, it gives up the contest and allows the foetus to expand its cavity at will, with the ultimate result that the foetus, given a free hand, continues ruthlessly to press upon the uterine walls to such an extent that it cuts off its own blood supply to the placenta, which thereupon dies. The foetus, beholding with fear what it has done, shrinks; the uterus, thereby released from some of its strain, seizes the opportunity, opens its mouth, belches forth its intruder, and collapses.

*BRITISH GYNÆCOLOGICAL SOCIETY.**ANNUAL MEETING.**THURSDAY, JANUARY 10, 1901.**DR. SMYLY, PRESIDENT, IN THE CHAIR.**Election of Officers.*

Dr. HEYWOOD SMITH proposed that the name of Dr. John Shaw be added to those of the Fellows nominated as Vice-Presidents by Council, as 11, instead of the usual number of 12, appeared upon the ballot paper.

Dr. HODGSON seconded the proposal, and it was carried unanimously.

The PRESIDENT announced that the ballot would close at 9 p.m.

*Treasurer's Report.*

Dr. MANSELL-MOULLIN, in presenting the Treasurer's report, said, I regret to draw attention to a falling off in the subscriptions during the past year. Considering the disastrous character of the period we have passed through, perhaps this is not to be wondered at. The profession has experienced the stress of the times, as well as all other classes, and the subscription, small as it is, is probably a matter of consideration to many. As a consequence we have been obliged to trespass somewhat on our balance.

The Journal, as you are aware, is the object upon which the funds of the Society are expended. This Journal is necessarily a very expensive matter. It has been found an unsuitable medium for the purpose of advertisement, and

cannot therefore be conducted on the economical lines of some other medical journals of similar character.

I am glad to say that under the management of our able Editor, Dr. J. J. Macan, it has well maintained its excellence and high reputation. The Journal is not only a record of the transactions of the Society, but a compendium of all the latest information bearing on the subjects of Gynæcology and Obstetrics. It is a Journal of which the Society has reason to be proud.

Naturally to those Fellows living at a distance and who are unable to attend the Society's meetings, the Journal constitutes the *raison d'être* of their Fellowship, and they would naturally expect it to be maintained at all costs.

This now concludes the eighth year during which it has been my privilege to hold the office of Treasurer, and it gives me great pleasure to hand over the duties of the post and the securities of the Society the same as I received them, to my successor, Dr. W. Travers.

Dr. Heywood Smith and Dr. Bennett have kindly looked through the accounts and audited the balance sheet.

Mr. BOWREMAN JESSETT moved that the Treasurer's report be received and adopted. He said that ever since 1892, when he had succeeded Dr. Edis, as Treasurer, Dr. Mansell-Moullin had carried out his work with the utmost ability. He thought it would be a pity if the Journal were not kept up to the same standard as it had been, and even if it entailed an increase in their subscriptions, he considered it advisable that contributors should have illustrations put into their papers when necessary, as it would very often considerably increase their value. He had great pleasure in proposing that the Treasurer's report be adopted, and also that a vote of thanks be accorded the Treasurer for the very able way in which he had conducted his duties during the eight years during which he had held that office.

Dr. HEYWOOD SMITH said he had much pleasure in seconding the proposal for the adoption of the report and also the vote of thanks to the outgoing Treasurer. He

The British Gynaecological Society.

Dr.		Cr.	
RECEIPTS AND EXPENDITURE FOR THE YEAR ENDING DECEMBER 31, 1900.			
To Balance brought forward December 31, 1899	£	s.	d.
„ Fellows' Subscriptions	203	13	2
„ Advertisements in Journal	367	5	7
„ Dividends on Investments	22	4	9
„ Interest on Deposit at Bank	10	10	1
	2	8	9
By Cost of Journal, Notices of Meetings, &c.	£	s.	d.
„ Rent and Attendance	262	11	8
„ Honorarium to Editors	54	15	0
„ Reporting and Sub-editing	78	15	0
„ Typewriter	26	5	0
„ Typing	24	19	6
„ Illustrations	12	5	0
„ Hire of Microscopes, &c.	4	19	0
„ Refreshments and Expenses of Entertainments	5	12	0
„ Bank Charges and Cheque Book	35	14	6
„ Postage, Secretaries and Treasurer	0	18	4
„ Expenses connected with Congress	11	12	6
„ Balance at Bank	28	19	6
„ in Hand	37	15	4
	21	0	0
	£606	2	4

We hereby certify that we have examined the above account, with the counterfoil receipt books and vouchers in connection therewith, and find it to be correct. We also certify that the Society holds the following Securities: £270 Grand Trunk Railway 4 per cent. Debenture Stock, £5 Caledonian Railway 4 per cent. Preference Stock, and £100 on deposit with the London and County Banking Company, all in the Treasurer's possession.

HEYWOOD SMITH, }  
C. H. BENNETT, }



thought he had a special claim to seconding that resolution, because Dr. Bennett and he had served the Society as Auditors for seven years, and during that time they had had the best possible opportunity of seeing the extreme accuracy and painstaking care with which Dr. Mansell-Moullin had filled the office of Treasurer. The year's work of going over the accounts had always been a pleasure, and if Dr. Mansell Moullin carried to the higher office of President, in which the Society were about to place him, the same energy and power of organisation, the Society would gain greatly by his occupation of it.

The motion was carried unanimously.

Dr. MANSELL MOULLIN, in reply, expressed much obligation to the Society for its very kind expression of approval.

#### *Editor's Report.*

Dr. J. J. MACAN, in reporting on his work as Editor-in-Chief of the Journal of the Society, said, he had in the first place gratefully to acknowledge the assistance of his colleagues, Dr. Arthur Giles and Dr. MacNaughton Jones, jun.; and if, in the judgment of the President and Fellows of the Society, the high standard which the Journal had reached under the able men who had preceded him had been approached during the past year, such success had to be attributed, in no small measure, to the very effective co-operation of the Assistant Editors.

The Proceedings of the Society, under the care of Dr. Giles, had extended to 250 pages, giving to each meeting an average space much larger than in any previous year, with the exception of 1899. To Dr. Giles also he was indebted for the *Précis* of the Proceedings in connection with the proposed International Congress of Gynæcology and Obstetrics, the publication of which prevented any further misinterpretation of the action of the Society, in inviting the Congress to meet in London in 1902, or after the invitation had been given.

Among the communications brought before the Society and included in the Proceedings, he might be allowed to refer to the particular interest of the valedictory address of Dr. Macnaughton-Jones, as retiring President, "On the Correlation of Sexual Function with Insanity and Crime," as a masterly exposition not only of the results of his own experience, but also of the opinions of the most eminent gynæcologists and alienists at home and abroad; to the Cinematographic Demonstration of Gynæcological Operations, by Dr. Doyen; to Dr. Macpherson Lawrie's paper "On the Indications for the Removal of the Uterine Appendages" and the discussion thereon at the June meeting. Many others, such as Mr. Stanmore Bishop's paper on "Preventive Measures in Abdominal Surgery," Dr. Heywood Smith's "On Treatment in Gynæcological Cases," might be mentioned, for none of the papers which had been read before the Society were unworthy of the interest with which they had been invariably received.

Dr. Doyen's demonstration had been supplemented in the same number in which it had been reported, by a translation by Dr. Warden of an article by Dr. Doyen upon the "Cinematograph as a Means of Teaching Surgery." The interest of this article was much increased by well executed illustrations. Another beautiful plate was the microscopic section of the malignant growth in the President's paper on "Sarcoma deciduo-cellulare," which had attracted much attention and had been reproduced in the *Practitioner*. The condensed translation of the review, by Professor Fritsch of Bonn, of "The Gynæcology and Midwifery of the last Quarter of a Century," had been retranslated for an Italian journal, and the source from which it was taken duly acknowledged (*Lucina*, No. 7, p. 102). Of the other papers not read before the Society, he would draw attention to Dr. Hebert's on "Kraurosis Vulvæ," with a complete list of the literature up to date, and to the article on "The Gynæcological Treatment of the Insane," by Dr. Ernest Hall, a Fellow of the Society practising in British Columbia.

The Journal Committee had met on many occasions, and the Minutes of their Proceedings had been regularly kept for the information of the Council. To give more prominence to the Proceedings of the Society and original matter, and to facilitate reference, the four quarterly parts of the Summary had been numbered consecutively, so that they might follow on at the end of the volume when bound. This alteration, which materially facilitates the making up of each number would, it was hoped, meet with general approval.

*Summary of Gynaecology and Obstetrics.*

In accordance with the desire of the Council, the Journal Committee had applied to a number of the Fellows of the Society asking them to assist in the work of its preparation by contributing to the Summary, or otherwise as they might be able, and several, whose names appeared on the cover as collaborators, had consented to do so. Many of these names would be familiar to the Fellows of the Society as having taken an active part in the Summary in past years. Now that this Summary had become such an important feature and extended to several sheets of small print, its compilation would be almost impossible without such help as these gentlemen had so kindly given. He would particularly refer to the condensed account of the Twenty-fifth Annual Meeting of the American Gynaecological Society, by Mr. Furneaux Jordan, to Dr. Jellett's report of the Gynaecological Section of the Paris Congress, and to the various abstracts from Russian and Italian sources by Dr. Edge, and those others initialled by Dr. Hebert. Special circumstances had that year prevented Professor Taylor and Mr. Martin from giving all the help they desired. Mr. Stanmore Bishop had done much in other parts of the Journal.

To all these gentlemen he would, with permission, offer his very sincere thanks, as also to those who had reviewed books for the Journal. He desired also gratefully to

acknowledge his obligation to his distinguished predecessor, Dr. Schacht, for his helpful advice whenever applied to.

Dr. Arthur Giles had, to the Editor's very great regret, decided on retiring from the editorial staff. The Council, in accepting his resignation, had recorded their appreciation of the very efficient manner in which he had worked for the Journal, and their sense of the loss sustained by his retirement. Measures had been under the consideration of the Journal Committee by which the work he had hitherto undertaken might be provided for, and an arrangement would be submitted to the meeting for its approval, which, if sanctioned by it, would, it was believed, prove entirely satisfactory.

*Vote of Thanks to Dr. Macan.*

Dr. TRAVERS said his duty was a very easy one. The way in which the Journal had been received, and the capable way in which it had been managed needed no words of commendation from him. He proposed a vote of thanks to Dr. Macan, the Editor of the Journal, for the able manner in which he had carried out his duties, and for the way in which he had made known to Fellows recent gynæcological literature.

Dr. EDGE said he had great pleasure in seconding the vote of thanks to the Editor of the Journal. No one could have done the work better or have taken greater pains with it.

The resolution was unanimously adopted.

*Vote of Thanks to Dr. Giles.*

Dr. PURCELL asked to be allowed to make a few observations with reference to the retirement of Dr. Giles from the Secretaryship of the Society. He was afraid he was taking the vote of thanks out of someone else's hands, but if not, he would propose that a vote of thanks be given to Dr. Giles for his unremitting attention to recording the



work of the Society. He believed that the Journal would not occupy the position it did had it not been for Dr. Giles. He was an expert in shorthand, as well as a past master of recording the thoughts expressed in the Society. It was in this respect that the loss of Dr. Giles' services would be felt. Before Dr. Giles assumed the Secretaryship of the Society, it had to employ a shorthand writer, and if he retired it would again be put to this very great expense. His services had been of inestimable value, and it was with great pleasure he proposed that Dr. Giles receive the thanks of the Society for the admirable way in which he had performed the very arduous duty of reporting and, at the same time, editing its transactions.

Dr. ROE CARTER said he had very great pleasure in seconding the vote of thanks to Dr. Giles for his able work, both in connection with the Journal and with the Society generally.

The PRESIDENT, in supporting the vote of thanks to Dr. Giles, said he did not think it could be expressed too strongly. Personally he felt under the very greatest obligations to him. When he had felt in difficulties he had often appealed to Dr. Giles for his advice, and had always found him both willing and anxious to help. He had been a model secretary, and would be a great loss to the discussions. As a reporter he had the faculty of relating what the Fellows would like to have said, and not, as was the rule with reporters, exactly the very things they wished they had not said.

The vote was agreed to unanimously.

Dr. GILES in reply said he could not sufficiently thank the Fellows for the way in which they had passed the cordial vote of thanks proposed by Dr. Purcell, seconded by Dr. Roe Carter, and supported by the President. He assured them that he appreciated most sincerely their appreciation of the work which it had been his privilege to do for some years past, and he hoped that his successors would find as much pleasure in it as he had done.

*Vote of Thanks to the Retiring President and other Officers.*

Dr. ROUTH, in a speech which was more than once interrupted by applause, said it was his high privilege to ask them on that occasion to return thanks to their worthy President for all he had done during his tenure of office, for his constant urbanity and for the valuable scientific contributions which he had furnished to the various discussions. His name was among those of the many Irishmen enrolled upon the Scroll of Fame. Not only was it familiar in the land from which he came, but it was known all over the world. He had performed his task with the greatest assiduity. It was no small matter to the residents of London to attend the meetings regularly, but it was infinitely more difficult for a man who had to cross the Irish Channel, to do so. He had brought fame not only upon himself, but upon the Society and upon all connected with it. They had been severely tried during the past year by those who, in self judgment, had found themselves to be superior. It was no small gratification to turn to the opinions expressed by disinterested observers in distant countries, and be reminded that whenever the Society had spoken, it had been to increase the esteem and respect in which it was held. His resolution was that the thanks of that Society be given, to the President for the great urbanity, zeal, and wisdom with which he had conducted its proceedings, and, to the members of Council and other Officers who had assisted him in his task.

Dr. ARMSTRONG said that the eloquent and exceedingly appropriate remarks of Dr. Routh left him but little to say. There was but one feeling among the Fellows of the Society as to the personal devotion of the President and other Officers for the past year, and that was, that it had never been exceeded. He was only echoing the feeling of the Society in expressing regret at the absence of Dr. Giles' name from the ballot paper.

The resolution was carried unanimously.

The PRESIDENT, in reply, thanked the Fellows most heartily for having placed him in the chair, and for the

kindly way they had overlooked his shortcomings, but especially for the manner in which the vote of thanks had been proposed and received. He also thanked them on behalf of the other Officers.

*Election of Officers and Council for 1901.*

The PRESIDENT, who had previously nominated Drs. Rotheroe and Macnaughton-Jones, junr., as scrutineers, announced, upon their report, that the Fellows whose names appeared upon the ballot paper had been unanimously elected.

They were as follows :—

*Hon. President.*—R. Barnes, M.D., F.R.C.P., London.

*President.*—J. A. Mansell-Moullin, M.A., M.B., M.R.C.P., London.

*Vice-Presidents.*—W. Armstrong, M.R.C.S., Buxton ; Clement Godson, M.D., London ; Skene Keith, M.B., F.R.C.S.Ed., London ; L. Landau, M.D., Berlin ; J. Macpherson Lawrie, M.D., Weymouth ; R. Milne Murray, M.D., Edinburgh ; James Oliver, M.D., London ; A. Pinard, M.D., Paris ; R. D. Purefoy, M.D., Dublin ; John Shaw, M.D., London ; Professor W. Japp Sinclair, M.A., M.D., M.R.C.P., Manchester ; Heywood Smith, M.A., M.D., London.

*Treasurer.*—William Travers, M.D., F.R.C.S., London.

*Council.*—W. Alexander, M.D., F.R.C.S., Liverpool ; A. H. Freeland Barbour, M.A., B.Sc., M.D., Edinburgh ; E. Stanmore Bishop, F.R.C.S., Manchester ; W. H. Bourke, M.D., London ; Professor Murdock Cameron, M.D., Glasgow ; John Campbell, M.D., F.R.C.S., Belfast ; G. Roe Carter, M.R.C.P.I., London ; John H. Dauber, M.B., London ; Ellis T. Davies, M.D., F.R.C.S.Edin., Liverpool ; Robert Hugh Hodgson, M.D., London ; F. Bowreman Jessett, F.R.C.S., London ; J. Furneaux Jordan, F.R.C.S., Birmingham ; George E. Keith, M.B., C.M., London ; H. Macnaughton-Jones, M.D., F.R.C.S.I., London ; T. Morton, M.D., London ; J. Inglis Parsons, M.D., M.R.C.P., London ; F. W. Ramsay, M.D., Bournemouth ; C. H. F.

Routh, M.D., M.R.C.P., London; F. F. Schacht, M.D., London; W. Dunnett Spanton, F.R.C.S., Hanley; W. J. Smyly, M.D., F.R.C.S.I., Dublin; Professor J. W. Taylor, F.R.C.S., Birmingham.

*Editors of the Journal.*—J. J. Macan, M.A., M.D., London; H. Macnaughton-Jones, junr., M.B., London.

*Hon. Secretaries.*—Charles Ryall, F.R.C.S., London; J. H. Swanton, M.A., M.D., London.

*Trustees of the Property of the Society.*—G. Granville Bantock, M.D.; Fancourt Barnes, M.D., F.R.S.E.; Clement Godson, M.D., M.R.C.P.

THE retiring President, Dr. W. J. SMYLY, then gave the following address :—

#### PRESIDENTIAL ADDRESS.

I have now to deliver a valedictory address, or, in plain English, to say farewell, a word associated generally with the pain of parting. But I hope that in this instance the parting is from the chair alone, and that in the future, as in the past, I may often occupy a seat on the benches and participate in your deliberations. It is easy to say fare you well, for seeing how you have done in the past, it requires little prophetic vision to predict that in the future your welfare is secure. There is, however, a vein of sadness inseparable from these occasions, for we recall the memory of those who, during the session, have left us never to return, and I have now to deplore the loss of two of our Fellows who have been taken from us by death, Dr. W. Chapman Grigg and Dr. Howell.

Dr. Grigg was a Foundation Fellow of our Society and a past President. I well remember our meeting at Newcastle-on-Tyne during his term of office, and how much his geniality and hospitable entertainment contributed to the success of that meeting. Dr. Grigg was chiefly interested in the obstetric branch of our work, and especially in antiseptics as applied to midwifery. Though he held the post of join



lecturer on forensic medicine in the Westminster Hospital Medical School, and was a physician to the Victoria Hospital for Children, Chelsea, he was for some time obstetric physician to out-patients at the Westminster Hospital, and also held the posts of physician to Queen Charlotte's Lying-in Hospital and acting physician to the General Lying-in Hospital, York Road. During the present campaign in South Africa he patriotically offered his services to his Queen and country, and like others of our profession, gave his life for both, falling a victim to enteric fever at Wynberg, on March 12, 1900.

#### PROGRESS IN GYNÆCOLOGY.

It is becoming every year more difficult to select a suitable subject for a valedictory address. A critical *resumé* of the work done during the session is quite superfluous when every member has our ably-managed Journal in his hands. At the commencement of a new century a review of the revival and development of gynæcology during that which has passed would have been particularly appropriate. As a science gynæcology is young, indeed not much older than myself; for when I was an "infant muling and puling in my mother's arms," Recamier was working with the then newly rediscovered instrument, the speculum, and, to the horror of his seniors, scraping out the uterus with the curette. How gladly would I have wandered along this seductive path, recalling the names of pioneers now laid to rest, but here again I found my way barred by our all-comprising Journal, in which you have doubtless seen an ample *resumé* of an address on this subject, delivered by Professor Fritsch. Another direction, and possibly more interesting, into which I might have directed your thoughts would have been the more recent additions to our therapeutic resources, such as atmocausis and zestocausis, serum therapy, and cocainisation of the spine. But here a worse barrier presented itself in the form of a personal agnos-

ticism as to their present value and scepticism as to their future prospects.

Finally, I have determined to illustrate the advance of our science by a brief review of one subject in gynæcology with which we are all familiar.

The history of the development of a scientific treatment of prolapsus uteri, commencing with an almost hopeless inefficiency, and carried forward in the face of repeated failure to ultimate success, is to my mind one of the most interesting in medicine, and will serve as an illustration of the general advance which has characterised the course of operative gynæcology during the latter half of the nineteenth century.

*Retroversion and Prolapse* may be regarded generally as one and the same condition, for although they may and do occur independently, yet in the majority of cases retroversion is a step in descent. Procidentia must have been diagnosed by the first woman who was afflicted by it, and the obvious treatment of reducing the hernial protrusion and preventing its recurrence most probably occurred to her also.

Pads, bandages, and pessaries were known to Hippocrates, and have been infinitely modified in succeeding centuries, but until quite recent times no real advance towards the cure of this condition was made or even attempted.

The first steps towards a rational treatment consisted in a study of the normal and pathological anatomy of the pelvic viscera and the mechanism by which the uterus is kept in place.

Mathews Duncan, in his "Lectures on Diseases of Women," asks the fundamental question very plainly, "What makes a woman's womb fall out of her body?" To investigate this we must inquire what keeps it in its place. This he answers correctly: "The most important cause is the pressure relations of the abdomen," but he spoils this answer by adding, "the womb floats." That is

a very confusing and incorrect statement, for in no proper sense could the uterus be regarded as a floating body ; and he further complicates the matter by giving an exaggerated importance to the retentive power of the abdomen. What is this retentive power ? I know not ; but that it is not a matter of much practical importance is, I think, sufficiently demonstrated by the success of treatment in which it is altogether ignored. A more practical and intelligible answer to the same question has been given by Fritsch, who, however, prefers to divide it into two. (1) What holds the uterus in its normal position ? and (2) what prevents its descent ? The first he answers by an illustration.

Take a book between your hands ; if it lie horizontally one hand supports it from below and the other secures it by pressure from above, but if it be held vertically it is liable to slip from between the hands, so the uterus lies upon the bladder and vagina, supported by the pelvic floor, and is pressed upon by the intestines above. As long as it lies horizontally, it can only descend along with the viscera which support it, but if placed vertically it could more easily slip between the viscera which surround it. If the lower hand were removed altogether the book would fall to the ground ; not so with the uterus, for if its supports were removed from beneath it would still hang by its ligaments. "The uterus is therefore kept in position by the intraabdominal pressure, but it is prevented from descending by the ligaments. A further development of the same idea led Hegar to divide cases of prolapse into two classes—namely, those which are due primarily to incompetence of the pelvic floor, and those which are due to inadequacy of the ligaments. In the former the lack of support is followed by cystocele, retroversion, supravaginal elongation of the cervix, descent of the uterus, and lastly, inversion of the posterior vaginal wall." In the latter class there is, first, retroversion and descent of the uterus without supravaginal elongation, and with inversion of both vaginal walls. Although usually combined, these two forms of

prolapse frequently occur as distinct conditions, and as they require entirely different treatment, I think the classification is of much practical importance. The proper understanding of the first form has resulted in great part from improved anatomical knowledge, and especially from the study of frozen sections. The ideas derived from the illustrations with which works on gynæcology were disfigured not many years ago, in which the vagina was represented as a widely dilated tube, with the uterus standing up unsupported in the axis of the pelvic brim, and the long axis of both lying in a line well known to students of those days as Carus' curve, were in themselves a complete bar to intelligent appreciation of the causes of prolapse. Our present knowledge of the normal position of the uterus we owe to Schultze, and in this country at least we are under a deep obligation to Dr. Berry Hart for his clear description and beautiful illustrations of the structure of the pelvic floor, especially the fact which he has pointed out that that floor is naturally divided by the vaginal slit into two triangles, the anterior supported by the posterior.

It is important to consider how this pelvic floor opens during labour.

As the foetus descends in the second stage the anterior triangle is drawn upwards out of the way, and the posterior is driven backwards by the presenting part. In the intervals between the pains the foetus recedes, being driven upwards by the levator ani muscle drawing the posterior triangle forwards, and the remainder of this stage of labour consists in a contest between the uterus and the levator ani muscles, a contest in which the latter are so stretched that they sometimes rupture, a condition to which Schatz drew special attention some years ago. But even where rupture does not take place these muscles may be so over-stretched that they do not regain their normal tone, and the posterior triangle ceases to support the anterior, which consequently descends, forming a cystocele. With an incompetent perineum and a cystocele prolapse of the uterus is only a question of time, the cervix is gradually



drawn downwards and forwards causing retroversion and supra-vaginal elongation, the long axis of the uterus thus comes to coincide with that of the vagina, and a condition most favourable to prolapse, clearly illustrated in Schultze's diagram, is brought about.

In the second class where the *peritoneum* is primarily at fault, the normal function of the ligaments is lost. That function is to replace the uterus when from any cause it becomes displaced, a fact which is easily demonstrated by artificially retroverting the uterus with the hands, when it will immediately replace itself the moment it is set free. Similarly when the bladder fills, the uterus is kept firmly opposed to it by its ligaments, and as it empties the uterus returns to its horizontal position. Where, however, the ligaments are inadequate from any cause, whether congenital or acquired, the uterus is not replaced by them and, the intestines falling in front, it is forced backwards by the intra-abdominal pressure until it comes to rest at the bottom of Douglas's pouch. This it will do in every case unless there be something to prevent the fundus sinking, a "slight retroversion" so reassuring to the nervous patient is really a complicated one, and most frequently due to adhesions. Adhesion of the uterus and its appendages was formerly looked upon as a bar to its descent, but abdominal operations have demonstrated that in a large proportion of cases of prolapse adhesions are present, and it is therefore evident that they do not prevent, but that, on the contrary, by keeping the organ in an unfavourable position, rather tend to facilitate its descent, and a free uterus, in which the fundus is driven down to the bottom of Douglas's pouch, is less liable to prolapse, than one which is held by adhesions, with its long axis in a line with that of the vagina, and its fundus exposed to the direct action of the intraabdominal pressure. We have learned thus from clinical experience, that so long as the uterus lies horizontally and the pelvic floor is intact, prolapse is impossible, no matter what strain it may be exposed to, and that where the ligaments are incompetent retroversion is the first step in descent.

In the face of these facts it seems to me most strange that some experienced gynæcologists still regard retroversion as in itself a matter of little consequence, and the many distressing symptoms with which it is associated, such as menorrhagia, leucorrhœa, inguinal, sacral, and bearing-down pains, as due to complications which alone require treatment. In my experience, apart from the importance of retroversion as the first step in descent, the complications which produce these symptoms cannot be relieved until the displacement has first been corrected, and when this has been successfully accomplished they will in time often disappear without further treatment. There are, no doubt, cases of retroversion, unattended by symptoms, which need no treatment, but they are not those in which there is descent, and with such only I am concerned at present.

#### TREATMENT.

In considering the treatment of prolapse I shall take Hegar's class, in which the ligaments are primarily at fault, first. In this group it is the retroversion which has to be corrected, for if the uterus does not turn backwards, so long as the pelvic floor is intact, it cannot descend.

The bladder and rectum being empty, the organ should therefore at once be replaced in anteversion, and this is best done bimanually, a vulsellum being used to fix the cervix in some cases. The uterine sound is seldom admissible, and should never be employed where adhesions are present. Where the bimanual method fails, an anæsthetic should be administered and another attempt made. Where adhesions are present the uterus should certainly be set free and replaced. This may be accomplished by massage, Schultze's method, or after cœliotomy. The first I do not generally recommend, not because I fear the opprobrium which attaches to it, partly from its abuse and partly from ignorance of the proper method of employing it, but because it has proved successful only in a small proportion

of cases, and because we possess better and more certain methods of accomplishing the same result. At the same time, I may mention that during the past year I have, by massage alone, succeeded in freeing a firmly-adherent uterus, and the patient now enjoys perfect comfort with a properly-adjusted pessary. The methods, however, which I consider better and more certain are Schultze's and abdominal cœliotomy.

Schultze's method at first appeared to me to be fraught with danger, but a long experience with a large number of cases has not as yet yielded a single mishap beyond, on a few occasions, a small hæmatocele, which was soon absorbed. However, I must add that lately I saw, in consultation with a colleague, a case in which his finger had perforated the rectum, and although cœliotomy was performed, and the peritoneum, as far as possible, cleansed, the patient died of peritonitis on the third day. The method is, nevertheless, in my opinion, a good one, but can only succeed where the adhesions are moderately soft. When the uterus is free or has been freed by any method excepting cœliotomy it should be maintained in position by a properly-fitting pessary; of these I employ but two varieties, namely the Smith-Hodge and the Thomas pessary with exaggerated curves. In most cases I prefer the former, but where the vagina is so relaxed that a very large instrument is required it would press injuriously upon the rectum. The Thomas pessary, however, whilst it lifts the posterior fornix high in the pelvis at the same time presses it forwards, away from the rectum. The original Thomas with slight curves is in no case as good as the Smith-Hodge, and I never employ it. When from any cause a pessary does not act satisfactorily, or if cœliotomy has been performed, it is better to fix the uterus by sutures. I have done a good many vaginal fixations by Mackenrodt's method, and with good results; several of these women have since borne children without difficulty or mishap; but considering the general results as reported by others, I have lately preferred

abdominal hysteropexy, and in doing so have generally adopted Howard Kelly's method of fixing the posterior aspect of the fundus to the peritoneum and posterior layer of the rectal sheath. I have also performed Alexander's operation, but not frequently, because abdominal operations are generally required where adhesions are present, and when coeliotomy has been performed it is simpler to stitch the uterus to the wound. Of the shortening of the round ligaments within the abdomen I have had no personal experience. The first class of prolapse where the pelvic floor is at fault is less amenable to treatment with pessaries. I therefore almost invariably advise operative measures in these cases, and only resort to rings and discs where such measures are either contraindicated or refused.

The earlier prolapse operations, such as Friche's episiorraphy, afterwards improved by Malgaigne and Marshall Hall, and the narrowing of the vagina, as performed by Marion Sims and others, as well as the operations of Le Fort and Neugebauer, were unscientific and unsuccessful, simply blocking the passage for a time, but a forward step was made by Simon and further improved upon by Hegar, which, by advancing the cicatrix upwards, tended to draw the cervix backwards, and Hegar's operation especially has been fairly successful.

Huguier, though mistaken in his views as to the ætiology of prolapse, rendered lasting service to the prolapse operation by introducing cervical amputation.

The complete operation as I regard it, and as I have now for some years performed it with satisfaction, consists in the following steps :—

- (1) Curetting the uterus.
- (2) Removing an oval piece of mucous membrane from the anterior vaginal wall and pushing up the bladder.
- (3) Amputation of the cervix.
- (4) Fixation of the uterus and anterior colporrhaphy.
- (5) Posterior colpoperineorrhaphy.

Considering the subject generally, our advance in



recent years appears to have been chiefly in the following directions :—

(1) *In Prophylaxis.*—The importance of a proper management of labour so as to prevent injury to the pelvic floor and sub-involution of the uterus and its ligaments, as well as pelvic peritonitis, is generally recognised, and in this connection one must again raise a warning voice against the early rupture of the membranes and the improper use of the forceps, especially their application before the os is fully dilated. The proper management of the third stage and of the puerperium are almost of equal importance.

(2) As regards operative treatment, success appears to depend more upon an intelligent appreciation of certain well-defined principles than upon any particular technique.

The first of these principles is the maintenance of the uterus in anteversion, and the second the restoration of the pelvic floor so that the posterior again becomes the supporting triangle and the vaginal slit again forms an acute angle with the long axis of the uterus. The first of these can be obtained by vaginal or abdominal fixation of the uterus or by Alexander's operation. I do not say that all these methods are equally good, or that any of them are ideally perfect, but as far as efficiency is concerned they all secure the desired end. As regards colpoperineorrhaphy, I may say the same. We now possess several excellent methods of performing this operation, all of which are more or less successful according to the condition of the levator ani muscles. These appear to me to be the two chief points, but there are others which, though of minor, are still of considerable importance, and should not be neglected; these are narrowing of the vagina, amputation of the cervix, and freeing of the uterus from adhesions. Before finally leaving this subject there are some other methods of treatment to which I would allude; one of these is extirpation of the prolapsed uterus. This operation I have performed three times, combined with anterior and posterior cclpor-

raphy and perineorrhaphy, and with success ; but the method does not appear to me to possess any advantages over the more conservative procedures. At the International Congress in Paris, last summer, I listened with much interest to Dr. Inglis Parsons' paper, in which he recommended and in which he recorded many successful cases to prove that injection of asolution of quinine into the broad ligaments will cure prolapse, but of this treatment I have no personal knowledge. What I have said of massage in regard to retroversion applies equally to prolapse—it has no doubt cured some cases, but not many.

In quitting your chair I must again thank you for the honour you have conferred upon me in placing me in such a position, and also for the forbearance which you have shown towards my many shortcomings. One virtue, however, I can claim, and that is that I have been regularly at my post, having been absent through unavoidable circumstances on one occasion only.

Dr. MACNAUGHTON-JONES said it was his pleasing duty, as Dr. Smyly's predecessor in the chair, to propose a hearty vote of thanks for the address to which they had just listened. The President had used the expression "Farewell" in addressing the Fellows, but they, in reply, would say "*au revoir*." They hoped on many future occasions, not only to have him among them, notwithstanding the maritime difficulties to which Dr. Routh had referred, but to hear him read many papers, such as, in the form of an address, had that evening given them so much pleasure. Had there been a discussion, it would not have embraced merely operative feats and technique, and it was to him, and he believed to other Fellows, a disappointment that none was possible. It was pleasant to deal with questions which they had to solve every day in practice, and those who were in daily contact with its difficulties knew that it was those very simple matters referred to in the address which often taxed to the utmost the patience of the patient and the skill of the surgeon. It was with pride that he had

given up the chair to Dr. Smyly, who had brought to it from his own country, not merely a personality, but a name associated with historical institutions in it of world-wide repute; who was not only an eminent gynæcologist but an obstetrician of skill and reputation, and, therefore, peculiarly qualified to occupy the chair of the Gynæcological Society. He hoped that Dr. Smyly might be long spared to add to the lustre which he had already given to the department of medicine which he adorned. He was not merely moving a formal vote of thanks, he felt that he was expressing the hearty appreciation of the Fellows of Dr. Smyly's conduct in the chair, his urbanity, the way he had conducted the discussions, and the general courtesy he had extended to all.

Dr. GILES, in seconding the vote of thanks proposed by Dr. Macnaughton-Jones, said that such an address, dealing with a specific subject in a historical and scientific manner, was not only pleasant to listen to, but was also of permanent value. He would not refer to the President personally, further than to say that he had no doubt inspired many of the younger Fellows, as he had inspired him, with a deep and sincere admiration, which would long outlive his tenure of the chair.

The vote of thanks was carried by acclamation, and

The PRESIDENT thanked Dr. Macnaughton-Jones and Dr. Giles for the too kind way in which they had proposed the vote of thanks. He disclaimed the urbanity which had been attributed to him. He feared his manners had been those of a Boer, for he had always run away before the conclusion of a discussion, and turned up fresh on the next occasion. He thanked them all most sincerely for the great honour which had been conferred upon him.

A CASE OF EXTRA-UTERINE FŒTATION INTO FOLDS OF BROAD LIGAMENT, WITH EXTRAVASATION OF ORGANIZED BLOOD CLOT INTO DOUGLAS'S POUCH.—OPERATION.—RECOVERY. By Dr. F. A. PURCELL, M.D., M.Ch. Surgeon to the Cancer Hospital.

S. A. C., aged 39, married, nine children, eldest aged 20, youngest aged 12 months, one miscarriage at eight months, gestation born dead; admitted to the Cancer Hospital on October 2, 1900.

Five months prior to admission the patient had ceased nursing, menstruation had reappeared, been normal in amount, and had lasted from four to five days. After the lapse of two months, during which she had seen nothing, small clots and dark red discharge began to pass, and from that time on—*i.e.*, during the three months preceding her admission—hæmorrhage had been practically continuous, though it might occasionally have ceased for twenty-four hours. About six weeks before admission pain came on in the lower part of the abdomen, and gradually increased, going through to the back. It was more severe on the left side. Difficulty in defæcation and micturition had been occasionally experienced.

The patient was thin, somewhat anæmic, and had been subject to fits (epileptic) since just before marriage, but had had none during the last three or four months.

The breasts were not full, but the areolæ were decidedly dark.

*Per vaginam.*—The os uteri was patulous, admitting two fingers, and was felt impinged behind the pubis. It was discharging blood. Its posterior lip was tumefied and protruded downwards. The sound passed three and a half inches, and the fundus was pressed over to the left and retroflexed. A well-defined, solid, fixed tumour occupied the pouch of Douglas and the right broad ligament, and could be felt per abdomen on deep palpation, as an indefinite tender swelling.



*Per rectum.*—The tumour was felt pressing against the anterior wall of the rectum, but the finger could not be passed above it.

*Operation.*—The abdomen was opened on October 10; the incision passing through the right rectus. A large (size of a cricket ball) adherent tumour of the right broad ligament was exposed. Above it ran the Fallopian tube, which was enlarged and thickened; but the corresponding ovary was not found. Much organized blood clot was lodged in Douglas's pouch. The body of the uterus appeared of normal size, but was deflected backwards and to the left. The left ovary was normal. The broad ligament was incised, and the cyst peeled, enucleated, and removed without being ruptured; some bleeding was arrested with hot sponges. The organized clot was removed with the fingers. It had evidently pushed down the posterior fornix, and had given, *per vaginam*, to the posterior lip of the os the feel of having a solid tumour. The abdomen was flushed out with warm saline solution; the edges of the peritoneum of the broad ligament were brought up and sutured to the abdominal peritoneum; an iodoform gauze drain was lodged in the broad ligament cavity; the abdomen was closed with silk-worm gut sutures passed interruptedly through the entire wall; and the usual dressings and bandage applied. The patient was returned to bed having borne the operation well.

*After treatment.*—The gauze was removed the following day and a rubber drain substituted for it. A good deal of discharge drained away, and continued to do so for four weeks. Eventually a silk ligature was hooked out, and the sinus closed. It was healed upon November 11, and the patient was discharged, having put on flesh.

Continuous with the hæmatoma was a small serous cyst; the Fallopian tube was so blended with the hæmatoma that only its uterine end could be differentiated.

The broad ligament cyst, when opened, was found filled with organized blood clots, and a probe passed through the tube showed that it and the cyst were in communication.

The cyst contents and the blood clot removed from Douglas's pouch were reported by the pathologist to whom they were submitted to be identical in structure with melanotic sarcoma.

The history of the case before and after operation, as well as macroscopical examination, led him (Dr. Purcell), however, to conclude that the condition was the result of an extra-uterine foetation. No foetal mole was found, but it might have escaped detection. He acknowledged his indebtedness to his house surgeon, Mr. J. Davies, for the notes which he had read, and for his treatment of the case.

#### NEW FELLOWS.

The following gentlemen have been elected Fellows of the Society :—

W. Jenkinson Corrigan, F.R.C.S.I., L.R.C.P.I., L.M.

William Jones Greer, F.R.C.S.I., L.R.C.P.I., L.M.

Richard John Cowen, L.R.C.P.I., L.R.C.S.I., L.M.

Paul Canton, M.D., B.Ch., B.A.O.Dub.

J. Keogh Murphy, M.A., M.D., B.C.Camb.

Thomas William Shepherd, L.R.C.S.Edin., L.S.A.

John S. D. MacCormac, L.R.C.P., L.R.C.S.Edin.,  
L.F.C.P. & S.Glas.

*BRITISH GYNÆCOLOGICAL SOCIETY.*

## THE ANNUAL DINNER.

THE Annual Dinner of the Society was held at the Café Monico on November 29, Dr. W. J. SMYLY, the President of the Society, taking the Chair.

The guests included : Sir Henry Roscoe, Vice-Chancellor of the London University ; Sir James Nicholas Dick, K.C.B., R.N. ; Sir William Thomson ; Sir Christopher Nixon, President R.C.P.I. ; Mr. C. B. Ball, Regius Professor of Surgery, Dublin University ; Dr. W. A. Elliston, President B.M.A. ; Dr. Milne Murray, President of the Edinburgh Obstetric Society ; Dr. Lombe Atthill, President of the Royal Academy of Medicine of Ireland ; Dr. Watt Black, and many others.

Among the Fellows present were : Dr. Bakewell, Dr. C. H. Bennett, Mr. Stanmore Bishop, Dr. Macdonald Brown, Dr. Dudley Buxton, Dr. Harry Campbell, Dr. Roe Carter, Dr. R. J. Colenso, Dr. Elder, Dr. F. P. Elliot, Dr. Haslam, Dr. Hebert, Dr. Hodgson, Mr. Bowreman Jessett, Mr. Robert Jones, Dr. Skene Keith, Dr. J. J. Macan, Dr. Macnaughton-Jones, Dr. J. K. Murphy, Dr. James Oliver, Dr. O'Connor, Dr. Putsey, Dr. M. J. Robinson, Dr. Rotheroe, Mr. Charles Ryall (Secretary), Dr. Schacht (President West London Med.-Chir. Society), Dr. Simeon, Dr. Heywood Smith, Dr. R. T. Smith, Dr. Smyth, Dr. Herbert Snow, Dr. Swanton, Dr. T. C. Temple and Dr. Thornhill.

Grace after meat was sung by the Westminster Quartet, who also gave the National Anthem after the toast of "The

Queen," proposed by the President, had been duly honoured, and sang a charming selection of glees during the evening.

In proposing the health of "The Guests," the PRESIDENT said that though many toasts which they would wish to drink did not appear upon the list, yet most of them were included in the one he was about to propose. The Navy their first line of defence, which had done such brilliant service in South Africa and the far East, was represented in the unavoidable absence of the Director-General, who should have responded to the toast, by Sir James Dick. Sir William Thomson, whom he might call the guest of the evening, had just returned from South Africa and would recall to their minds the Army, which had done such noble work in securing liberties and equal rights to all men in that part of the world. They were justly proud of the services of the Irish Hospital, of Dr. George Stoker who planned it, of Lord Iveagh who paid for it, of Sir William Thomson who conducted it, and of the brave and self-denying men and women who formed its staff. On his left hand sat the President of the British Medical Association—the greatest medical society the world had ever known. Beyond him Sir Christopher Nixon, the President of the Royal College of Physicians in Ireland, and beside him the President of the Obstetrical Society of Edinburgh. Beyond him Dr. Watt Black, a past President of the Obstetrical Society of London, one of the oldest and most famous of the medical societies. Dr. Black had been an assistant of Sir James Y. Simpson, the greatest obstetrician Great Britain had ever produced, and its first gynæcologist. Beyond him sat Dr. Lombe Atthill, President of the Royal Academy of Medicine in Ireland, a gynæcologist of European celebrity. On his right sat Sir Henry Roscoe, too well known to need any introduction to them. He represented the London University, of which he was the Vice-Chancellor, and the Victorian Institute of Preventive Medicine; and beyond him was Dr. Ball, the Regius Professor of Surgery in Dublin University. Many other dis-



tinguished visitors were present, and with those he had mentioned represented a variety of interests which they would include in the toast of their Guests.

The toast having been received with acclamation, Sir JAMES DICK briefly but warmly acknowledged the gratification he felt in responding to the kind way in which the President had coupled his name with the Navy, the medical department of which he had had, till lately, the honour of directing, and thanked the Fellows of the Society for the good fellowship and courteous hospitality with which they had welcomed him.

Sir WILLIAM THOMSON followed, and referred to the work done by the Irish Hospital in South Africa and its mobility. He described the march from Bloemfontein to Pretoria with Lord Roberts, dwelling upon the endurance, discipline, self-denial, and courage of the British soldiers, warmly repudiating the imputations which had recently been uttered by Mr. Kruger with regard to the British Army. He deplored, as exaggerated and unpatriotic, the letters which had appeared with regard to the treatment of our soldiers in the campaign. He had not himself seen anything to justify such representations; considering the exigencies of war, everything that could be done had been done. The Palace of Justice, a splendid building in Pretoria, in which the Irish Hospital was established, offered exceptional advantages for the care of the sick and wounded. Within four days of its being given up to them they were able to accommodate eighty wounded, and their results would compare favourably with those of home hospitals.

The PRESIDENT of the BRITISH MEDICAL ASSOCIATION, in proposing the toast of the British Gynæcological Society, thanked the Council of the British Gynæcological Society for their courtesy in placing this toast in his hands, which he took to be an indirect compliment to the Association of 18,000 members, over which he had the honour to preside. When the medical history of this century, now within a few weeks of its expiration, was written, he thought one of its

striking features would be the great advance in special studies, which were chiefly due to such associations as theirs. In the last century there had been attempts by William and John Hunter, and Jenner, which were in part successful, but it is only in this century that these societies have been placed on a more lasting foundation.

Dr. Elliston went on to say : I believe the oldest of these societies in any way devoted to gynæcology is the Edinburgh Obstetrical Society, established in 1840, whose president is with us to-night ; then came the Obstetrical Society of London, which was established in 1858. At its first meeting Dr. Rigby was in the chair, and its formation was determined upon by a resolution, proposed by Tyler Smith and seconded by Dr. Granville, who, in 1825, had made an unsuccessful attempt to establish a similar society at a meeting presided over by Sir Charles Mansfield Clark.

After the establishment of the Obstetrical Society the special branch of gynæcological science made such rapid strides, due to the eminent men engaged in its practice—among the many, such men as Simpson, Clay of Manchester, Tyler Smith, Baker Brown, Spencer Wells, Keith, Lawson Tait, Marion Sims and Emmett, of New York, Lombe Atthill, and others, some of whom are happily still living—that it was, I think, felt that the old distinction of physician and surgeon did not meet the case, since a gynæcologist must be both a cultured physician and a dexterous surgeon ; and it is not, therefore, surprising that among the younger practitioners of that period it was deemed desirable to form a fresh association, and in accordance with these aspirations a meeting was held, December 27, 1884, with Dr. Routh in the chair, and it was then moved by Dr. Robert Barnes, and seconded by Dr. Heywood Smith, and carried unanimously, that the British Gynæcological Society be established. The election of officers was then proceeded with, and Dr. Alfred Meadows was elected its first President.

The new Society received considerable support from all

parts of the kingdom, so that the Secretary was soon able to report the adherence of 266 Foundation Fellows.

Your first President was known to me probably before any Fellow now present. He was a pupil of my father's, and I knew him from that time. He was a man of remarkable energy and perseverance, and well deserved the eminence he afterwards attained, although cut short while yet a young man. From the time of your first President, you have been fortunate to secure a long roll of eminent men to preside over you, none more so than the occupant of the chair this evening. It was my good fortune to hear his admirable address at the Ipswich Meeting of the British Medical Association. His eminence is admitted and his private worth is known to the Fellows of this Society. I beg to propose "Success to the British Gynæcological Society," coupled with the health of your President.

In replying to the toast of the British Gynæcological Society, the PRESIDENT said it was most appropriate that the toast should have been proposed by the President of the British Medical Association, because what that Association was on a large and inclusive scale their Society was on a smaller scale, and in a more limited sphere. He wished to emphasise the fact that theirs was not a London Society, for had it been he would not have occupied the position he did, nor was it a provincial Society, but a British Society, which included amongst its members gynæcologists in every part of the British Empire. He was glad to be able to tell them that the Society was in a flourishing condition, its roll of members was as large as ever, the meetings well attended, and the subjects brought under their consideration had been as full of interest and as keenly debated as during any previous session. They regretted that circumstances had arisen which prevented the International Gynæcological Congress accepting their invitation to London, and they felt certain that the belief expressed by the Secretary of the Founder's Committee of that Congress, that had they decided

to come to London the Congress would have been a brilliant success, would have been realised.

The toast of "The Universities and Medical Corporations" was proposed by the President of the Obstetrical Society of Edinburgh, Dr. MILNE MURRAY, who said : I rise with somewhat mixed feelings to propose the toast of the Universities and Medical Corporations, because while I appreciate the honour of being selected to discharge this duty, I feel that there are many here who could commend the toast to you with greater skill in words than I can claim. But at the same time I feel that a toast such as this does not require much commendation in such an assemblage as this, and that its acceptance on your part is not imperilled by any feebleness of expression or poverty of ideas on mine. And first let me say that it seems very appropriate that these institutions—Universities and Corporations—should be associated in one toast on this occasion, because, from a medical standpoint, they are in a sense complementary of each other.

I venture to think that the purpose of a university is twofold. Its duty is, in the first place, to teach. We, as medical men, look to the Medical Faculties to impart a sound scientific knowledge of medicine to their students and to lay down the lines of equally sound practice. That the Faculties are doing their best to discharge this duty I think we must generally admit. The younger Universities are vieing with the older, and the older are vieing with each other, in an endeavour to equip themselves with skilful teachers and with adequate appliances to meet the demands of modern medical teaching ; and while they are in some cases hampered by tradition and in others by limited resources, they are, on the whole, proving themselves thoroughly in earnest in the discharge of this fundamental duty. But a university has another and not less fundamental duty. It must not merely hand on the torch of knowledge, it must see that this torch is kept brightly burning—not with a dull, smoky flame, serving only to make the darkness visible, but with an efful-



gent radiance which will shine into and illuminate the dark corners of the earth. There is indeed some danger that the eagerness to discharge the duty of teaching the truth may overshadow the duty of seeking the truth, and a university which fails in this fails in the fulfilment of its primary object and purpose.

We, in the far north, have been watching with sympathetic interest the somewhat prolonged and lingering labour which has resulted in the second birth, the regeneration, if I may so speak, of the University which takes its name from the great city. Our sympathetic interest was at times not unmixed with anxiety, for we feared that the infant might succumb from the very tediousness of the parturition, or that some operation might be necessary which might affect its viability, or even summarily destroy its vitality. But we rejoice to see an infant lusty and strong, which we hope, in virtue of its new organisation and environments, will reach a vigorous manhood and a green, but never a senile, old age. It will do so, I venture to think, if it discharges the two functions of a university I have referred to in a reasonable and earnest spirit. The Medical Corporations have likewise, I take it, two functions. The first is to create and to maintain a standard of professional conduct, and this, I think all will admit, they discharge in a wholly admirable way. Their second function is to act as a filter, as it were, between the medical schools and the confiding public. I use the term "confiding" in no oblique or sinister sense, because I am sure that the public have, on the whole, every reason to rely on the efficiency of the process by which products of the schools are classified and chosen for the public good. I am well aware that there are some who are not wholly satisfied that all the details of the process of selection are as perfect as they might be, but from a considerable experience of examiners and examinations I have confidence in saying that the work is conscientiously carried out by those responsible for it.

I have great pleasure in coupling this toast with the

name of Sir Henry Roscoe, who spent many years of his life in one of the most vigorous of our younger universities as a teacher and investigator, winning for himself a world-wide renown and shedding lustre on the school in which he worked and taught, and who now, as Vice-Chancellor of the University of London, is giving the newly organised University the benefit of his mature wisdom and experience ; and I have also to associate with this toast Sir Christopher Nixon, President of the Royal College of Physicians of Ireland, a distinguished representative of Irish Medicine, and the worthy head of an ancient and honourable corporation.

Sir HENRY ROSCOE, who replied for the Universities, briefly sketched the outlines on which the University of London would be conducted. There would be the same liberal attitude to all, both men and women, who could take advantage of its teaching and degrees. At the same time, the high standard which had been aimed at by the London University in the past would be strictly maintained. He referred to the Jenner Institute as a great means for the advancement of medical science, so great that it was hardly appreciated to the extent it ought to be, and to which the great liberality of Lord Iveagh had so largely contributed.

Sir CHRISTOPHER NIXON also replied for the Medical Corporations in an interesting speech.

## ORIGINAL COMMUNICATIONS.

## INFLAMMATION OF THE FALLOPIAN TUBES.

BY E. STANMORE BISHOP, F.R.C.S.

*Honorary Surgeon Ancoats Hospital, Manchester.*

EVER since it became possible to diagnose salpingitis, as distinct from inflammations of the pelvic connective tissue gynaecologists have recognised that, in certain cases, sup-puration occurred ; that the pus thus formed distended the closed tube, closed in the early stages of that inflammation ; and that the tube became thus converted into an abscess sac, of which the ovary might or might not be a part, the presence of which was a continuous menace to the life of the patient, who, so long as it was retained, led a life of invalidism, broken only by accentuated attacks of intense pain, when through any cause, fresh acute changes were set up in it or in its vicinity. Naturally the first and imperative indication appeared to be its removal by the most convenient route. Operators have been divided as to which, the vaginal or abdominal, operation was the best ; those in favour of the former pointing out that the tube in such cases tended to sag downwards from its own weight into Douglas' pouch, and could most easily be reached by a posterior colpotomy. They also showed that in many instances, the pus tube was firmly adherent to the peritoneum in this region, so that an opening in this direction directly gave exit to the purulent accumulation, permitting of its free escape without any interference with the other contents of the abdominal cavity. That, in some instances, this was all that was necessary, free drainage resulting in a

gradual obliteration of the tube, and sound healing. That, in other cases, where the tube was not so adherent, by its altered position and the comparative freedom with which it could be isolated, brought down, and removed, a comparatively safe and rapid operation could be substituted for one which was more risky and far more tedious ; and besides that the drawbacks to the abdominal route were great. In the first place this necessitated an opening in the anterior abdominal wall, with its consequent scar, and—at that time—risk of ventral hernia; that when once this wall was open, the operator was met by extensive adhesions, the omentum being usually plastered over the parts affected, frequently coils of intestine were involved in the adhesions, necessitating a tedious and dangerous process of separation ; that supposing all this was successfully overcome, drainage in this situation was almost impossible. That complete removal became imperative, that such complete removal meant the careful separation of the pus sac from the posterior wall of the broad ligament, a separation not unfrequently attended by small tears in the abscess wall, permitting the escape of pus which might be virulent ; that if this pus escaped, soiling of fresh intestinal coils, or of the parietal peritoneum was very probable, and that thus an acute septic peritonitis might be set up, causing rapid death. Theoretically, it would seem that the case was abundantly proved in favour of attacking these purulent accumulations by the vaginal route.

But various improvements in the abdominal operation have lessened the force of these objections, whilst corresponding objections to the vaginal route must not be overlooked. Amongst the improvements referred to, perhaps the most notable has been the introduction of the Trendelenberg position. No longer are the hands and eyesight of the operator impeded by clinging coils of gut, which, in the old dorsal position, were constantly obtruding themselves through the abdominal opening, as soon as the upper adhesions were separated, and thus preventing ready access to deeper ones. Tait attempted to overcome this difficulty



by making a very small opening, and trusting entirely to his sense of touch ; but not all men could so trust. With the majority in anything like a severe or complicated case it was necessary to be able to see as well as to feel, the difficulties encountered. With the new position, all intestine tends to sink away towards the diaphragm from the line of incision. As each adhesion is loosened the tissues affected by it sink out of sight, whilst the next to be attacked is placed on the stretch, and the plane of union becomes more and more evident. When once all covering omentum and intestine is out of the way sponges can be placed beneath all doubtful parts so that if leakage occurs the escaping pus is absorbed by them, thus protecting the other abdominal contents. The increased view of the field enables the operator to proceed more cautiously and more correctly, and to apply his force more evenly and to better purpose. Moreover, it was found that the pus in the affected tubes was frequently not virulent at all, that the micro-organisms which originally produced it had perished, apparently by the very havoc they had made, and that what now escaped was practically pure *débris* alone, with no very great power of harm, even if it did come into contact with virgin peritoneum. Lastly, Clark, of Johns Hopkins University, proved that the peritoneum itself had hitherto unsuspected powers of protective absorption, when it was no longer teased and trammelled by the old methods of drainage. The drainage tube once eliminated, away with it went the most potent cause of sequent ventral hernia, whilst new and improved methods of uniting the abdominal wall rendered that evil result practically non-existent.

As the objectionable features of the abdominal operation were got rid of, those of the vaginal assumed proportionally more importance. The immediate result in life or death to a patient is a great thing. It is no doubt the paramount consideration, but the after results are to the sufferer who survives of almost equal value. No one would willingly undergo a serious operation with an almost certain prospect

of prolonged invalidism, with risks of renewed acute attacks almost indistinguishable—to her—from those previously experienced.

In the vaginal operation if we are so fortunate as to encounter a case in which the inflamed and suppurating tube can be entirely removed by this route, we have, without doubt, in this way performed the best, safest and most satisfactory operation ; but this is by no means always, or indeed in the majority of the cases, the fact. Far more often we encounter a tube which is so adherent above that its entire removal by this method is simply impossible. We can only incise and drain. It may be our good fortune even then to obtain sound healing, the pyogenic lining membrane of the tube is thrown off and the rest contracts. But the risks of this process are many and not without great danger later on. The opening in the tube may contract and a re-accumulation take place, with a repetition of all the old troubles and dangers the operation was intended to remove. Should this not occur, the very adhesions above, which induced us to proceed by this route, as the tube contracts and closes, drag upon the parts above, upon the bladder, coils of intestine, and through the omentum upon the transverse colon and stomach, causing possibilities of intestinal obstruction through kinking of the intestinal walls, and prolonged and practically incurable dyspepsia, incurable that is, unless a fresh abdominal section is made and the traction relieved by a separation now more difficult, as all secondary operations about the abdominal cavity are, by reason of displacement of structures, and the increased density and intractability of their pseudo-connections. Thus it will be seen that we have gravely discounted the future comfort of our patients in favour of their more immediate safety.

I am far from saying that this is not advisable in some cases, and in one case to be related, that of Mrs. C., No. 6, I have always regretted that, at all events, in the first place, I did not content myself with simple incision and drainage.

The case, as will be seen, was an exceptional one, however, and I still believe that in most cases, absolute and total removal is the only course which ensures to us the final safety and complete recovery of our patients ; and that this total removal is more surely and completely effected by the abdominal route.

The following cases are, to a certain extent, illustrative of the position held, and of the difficulties most commonly encountered.

CASE 1.—S. I. M., aged 23, admitted to Ancoat's Hospital October 4, 1894. Menstruation began at 11 years, has always had pain before and after each period which recurred about every three weeks ; periods last six to seven days. Only confinement four years ago, has never been well since. Confinement was severe and tedious, lasting four days. Convalescence lasted one month. Child was suckled for six months, stopped then because patient was in bed for two weeks with pelvic pain and vomiting. Leucorrhœa, which had been slight before the confinement has been profuse ever since, and the discharge has once or twice been offensive.

For the last three years has suffered from prolapsus uteri, for which a pessary was inserted ; six months ago, this caused so much pain that it was removed.

Since her confinement, menstruation has occurred about once in six months, associated with pain, before, during, and for two days after its appearance. Period now lasts seven days, the last period, just over, has lasted fourteen days. Complains of constant pain over the sacrum, ilia, down the outer side of the right leg as far as the foot, and along the under side of the left leg to the knee. Has suffered from hæmorrhoids ever since her confinement.

*Per vaginam.*—The os uteri is split mainly on the right side. The uterus is enlarged, the right Fallopian tube thickened and tender ; nothing to be felt on the left.

Hot douching and ichthyol tampons were used for about three weeks. Under this treatment the uterus became smaller and much less tender, whilst the mass on the right side became more distinct. At the end of that time, abdominal section was performed, and the right tube was found thickened, inflamed, adherent to, and forming one mass with the right ovary ; the

whole was adherent to small intestine and omentum. These adhesions were separated by the fingers, the mass brought up and removed. The uterine end of the tube was closed by fine Lembert's sutures. Abdominal wall closed without drainage. Recovery.

CASE 2.—A. W., aged 31, admitted Ancoat's Hospital, June 22, 1896. Thin, dark, pallid woman, two children, youngest five years old. Two years since suffered from "inflammation of the bowels." For the last three months has suffered from continuous pain in the right hypogastrium; this has become intermittent during the last month. Menses were perfectly regular until the last six weeks, during which time she has had three large losses of blood.

There is marked tenderness over the right inguinal region. Bimanually, a mass is felt on the right side of the uterus, which is rounded, tense, with marked pulsation of the uterine artery stretched across it. The body of the uterus is pushed over to the left; the os being drawn to the right.

June 26.—The patient being in the Trendelenberg position, an incision is made in the median line. The right ovary is greatly enlarged and cystic, one cyst containing offensive pus. The whole mass to which the tube was closely adherent was the size of a lemon. Small intestine and omentum were adherent to it. The tumour was peeled off the broad ligament, to which it appeared at first absolutely fixed. Whilst this was being done, two cysts gave way, including one small pus sac. All was sponged clean, a glass drainage tube being left. On removing the mass, the fundus of the uterus was bared of peritoneum. Adjacent peritoneum was drawn over it, and this and the open edge of the broad ligament were closed by catgut suture.

The abdominal wound was then closed around the tube. At first, and for two days, fluid was withdrawn from the tube every hour; it was sanguinous and varied in amount from 5 drachms at first to  $1\frac{1}{2}$ , and even half a drachm. By the 28th, the fluid had become light coloured, and was withdrawn every three hours; amount then was  $\mathfrak{z}$ iss. On the 30th it began to show flakes of pus, to increase slightly, and to smell. By July 4 the amount of fluid within had increased to  $\mathfrak{z}$ ii. in the three hours, and had a strong faecal odour. The tube was raised, and rotated at each dressing. On the 8th the glass tube was pushed out, and was then removed, and a rubber tube inserted; dis-



charge still smelling fœcally. The smell continued until the 11th, when the amount decreasing, and there being no further smell, the rubber tube was finally removed on the 12th, after having been in position sixteen days.

The bowels were moved on the third day, after calomel and turpentine enemata. The catheter was required more or less for fifteen days. The skin wound was noted as healed by the sixth day with the exception of the opening for the tube. This was not finally closed until the middle of August, more than six weeks after the operation.

At this time (1896), it was generally considered necessary to insert a drainage tube, especially if any pus had escaped during removal, and the case shows very well, I think, the difficulty which ensued from the use of this appliance. So far from decreasing, the amount of fluid steadily, though slightly increased. Very soon pus was formed, and the apparent need for the tube became emphasised. Later still, the fluid smelt fæcally, and though no actual fæces appeared, it seemed more necessary still to provide for its exit. In a later case, indeed, as will be seen (Case 4) an actual fæcal fistula formed, and the *post mortem* examination showed an opening in intestine which corresponded in size and position with the internal end of the glass tube. It is probable too, that the irritation produced by the tube had much to do with the prolonged urethral spasm, which constantly necessitated the use of the catheter in this case. The next case contrasts, I think, most favourably in this respect. It was one of the first in which I discarded the drainage tube, trusting entirely to the powers of the peritoneum.

CASE 3.—M. I., aged 27, admitted to Ancoat's Hospital June 27, 1896. Menstruation commenced at 16 years of age, and recurred every three weeks. Is thin, and worn looking. Has never been strong. When 12 years old, suffered from "fever," and from epilepsy during school life.

Has had one child, seven years ago. The confinement was normal, but on getting up at the end of eight weeks, she flooded, and was plugged by the medical man attending her. Has never felt well since.

Complains of much pain in the lower part of the abdomen, right inguinal, and sacral regions after every menstruation since her confinement. Was usually free from pain during the intervals until the last period, three weeks since, since that time it has been persistent. The periods have been regular but profuse.

The uterus is fixed. The left fornix is filled by a large fluctuant elastic mass. On the right side there is a smaller rather firmer swelling. The os uteri is deeply split.

*July 10.*—Patient on inclined plane. Abdomen opened in median line. The left tube and ovary are transformed into a large abscess sac firmly adherent to the broad ligament. Flat sponges were packed beneath. Whilst detaching the sac it tore, discharging a thin, brownish, ichorous pus, without smell. On the right side there were several long and thin or flat adhesions, all of which were tied, and divided. The cavity, left after enucleation, was washed out with normal saline solution and carefully dried. The abdomen was closed by tier suture without drainage.

*July 12.* Temperature had reached 99.6° at 10 p.m. on 11th, pulse 120, respiration 28. To-day (10 a.m.) temperature 99.2°, pulse 110, respiration 24. Calomel in half-grain doses every hour was commenced at 4 p.m. on the 10th—operation being over at 1 p.m.—and repeated for 8 doses. At 6 p.m. she complained of pain which increased up to 8 p.m. when  $\frac{1}{8}$  gr. of morphia was given hypodermically. She commenced to vomit at 8.45 p.m., and continued to do so at intervals of half to one hour until 11 a.m. on the 11th. There was no further vomiting until 5.30 p.m., since when she has vomited about once in every four hours. There was persistent hiccough until 7.30 a.m. on the 11th when it ceased, to return slightly at 3.30 a.m. on the 12th.

Urine was passed normally at 4.30 p.m. on the 11th and flatus at 8 a.m. on the 12th. Half a seidlitz powder was given and repeated each hour for three doses, all these were vomited. A turpentine enema was given without result. A nutrient enema was given every four hours and retained until midnight on the 11th when it returned. This also happened with the next at 4 a.m. on the 12th. Those, however, at 8 a.m. and 12 noon were retained.

*July 16.*—A discharge of blood per vaginam commenced on

the 11th ceasing this morning, and followed by brownish offensive fluid, which continued until the 20th. At 2 p.m. on the 12th (flatus having already passed) an enema of soap, water and castor oil was followed by a free action. Soda water and milk were then given and retained. On the 13th Benger's food and beef-tea were given. On the 14th milk, eggs, beef-tea, custard, bread and butter. Bowels freely moved again on the 13th and 14th.

August 1.—Discharged well.

In this case we were naturally very anxious at first. The amount of work thrown upon the peritoneum appeared to be too much for it. Muscatello has shown that the main point at which foreign material leaves the peritoneum is the diaphragm; that carmine injected into the cavity is carried through its lymphatics into the retro-sternal glands, where it first appears. The vomiting and hiccough noted during the first twenty-four hours apparently pointed to excessive irritation in this region, and its persistency led us at first to regret our action in depriving ourselves of what we had been accustomed to look upon as a safety valve—the glass drainage tube. But the later progress of the case was very reassuring, and the much more rapid progress afterwards seemed to prove the ultimate wisdom of the course adopted. In the next case still more evidence was seen of the superiority of immediate closure over drainage by the old methods. The cause was a recent one, therefore it might reasonably be suspected that the organisms were still active; the internal traumatism was greater, the pus sacs were large, and one of them had to be evacuated *in situ* before it could be removed. My own experience of immediate closure was not then large, and it was thought safest, therefore, to leave a tube. Yet the patient died and the death was evidently due, as far as we could judge, to the effects of the tube, and to that alone. A later case (Case 10) throws still more light upon this question, since in that the circumstances were almost parallel, and yet recovery followed after a period of considerable anxiety, it is true, but without

any of the worst features encountered in that now to be related.

CASE 4.—M. A. T., aged 33, admitted November 14, 1896.

Confinement seven weeks since, followed by rigors on the third day and great pain in the right inguinal and iliac regions.

Fat, flabby woman, medium height. Bronchitic râles all over chest. The uterus is fixed with two large, rounded, elastic masses on either side.

Operation was postponed for a few days in order, if possible, to eliminate the bronchitis, but the temperature rose steadily from 100° on admission to 103° on the 22nd of November, with the characteristic morning remissions.

*November 24.*—Abdominal section. The omentum was found much thickened and widely adherent. The appendix vermiformis was adherent to the left ovary, which is embedded in strong adhesions; the mesentery of the former was matted together in such a way that two tubes appeared to spring from the cæcum. It was removed after ligature, and the peritoneal coat united over the stump. From the pus sacs, about one inch of small intestine was also separated with some little difficulty. On the right side strong adhesions required separation before the greatly distended right tube could be brought up. It was raised to the level of the abdominal wall, sponges being placed beneath and around, and opened. About one ounce of pus was evacuated, after which the emptied cyst could be brought out, tied, and removed. The left tube appeared healthy, but the corresponding ovary had a central abscess whilst a smaller one was also found in its outer wall. Bleeding from the separated adherent parts was pretty free for a while, but soon ceased. The main points having been tied, some raw surface was perforce left on the left side of the uterus, and behind both broad ligaments. A glass tube was passed down into Douglas' pouch, and the rest of the abdominal wound united in the usual way.

*November 25.*—The temperature fell to normal during the night, is now 101.4°, the abdomen supple, pulse 144, respiration 82. There is persistent coughing which is very painful. Has passed flatus per rectum, and six ounces of urine by the catheter; later in same day this was passed naturally. She is given whiskey and is inhaling the vapour of Tr. Benzoin Co. Nutrient enemata with brandy. Iodine tincture is applied to the chest.



Fluid is drawn from the tube every two hours. Sleeps for half an hour at a time.

*November 26.*—Temperature has risen to  $103.6^{\circ}$ . The fluid coming from the tube is purulent; pulse 160; respiration 56; no vomiting; cough still troublesome. As it was thought that the interior of the uterus might be septic, it is curetted and washed out with perchloride solution 1 to 1000. The tube is washed out with peroxide of hydrogen. Fæcal material appeared in the tube at 8.20 p.m. The temperature came down after curetting to  $100^{\circ}$ , and although very irregular did not rise much above this until December 2, when it reached  $101.6^{\circ}$ , falling again until just before death when it reached  $102^{\circ}$ . The respirations ranged from 40 to 60, the pulse from 144 to 170.

On October 29 the abdominal wall with the exception of the peritoneum had broken down around the tube and the abdomen was tympanitic. Fæcal material continued to come through the tube up till death which occurred on December 5.

*Post-mortem.*—The abdominal cavity showed evidence of acute peritonitis. In one coil of small intestine a sloughy rounded opening, about the size of or rather larger than the calibre of the glass tube, gave exit to fluid fæcal material, which had been prevented from general distribution by adhesions around.

*CASE 5.*—J. H., aged 24, admitted Ancoat's Hospital April 8, 1897.

Menstruation regular and painless up to marriage six years ago. One child five years since. Miscarriage three and a half years ago, has never been well since. Miscarriage took place during absence from home, which she had some difficulty in regaining. After going to bed sent for her doctor, who removed the placenta. Remained in bed for fifteen days, was up and about for two days, when she was attacked by inflammation of the uterus, which kept her in bed for seven weeks. Since that time she has had four similar attacks, all pretty severe. Each attack is associated with vomiting, and begins with pain mainly on the right side. Has never gone a full month since the miscarriage. There is some pain before urination, relieved by the act.

On admission the uterus is found large, heavy and tender, the os hypertrophied, split. The tubes at that time appeared normal.

*April 9.*—The uterus is curetted and mopped out with zinc

chloride solution. After irrigation Duke's intra-uterine wire tube is introduced as a drain. This was removed on the 12th and found blocked with clot. After cleansing it was replaced.

*April 18.*—Still wears Duke's tube; has been irrigated daily; blood-stained discharge issues freely from the tube. The temperature has been about normal since the curetting. Rose to 99° on the 17th, but has fallen again to 97°. There was some pain on the 16th; now ceased. Discharge is now brownish. Complains of an aching, drawing sensation.

She left the hospital on May 1, but returned May 25. She says that pain over the sacrum and in the right inguinal region commenced as soon as she began to walk about. It is now continuous, even when lying down. There is now a fixed and painful mass in Douglas's pouch, the pain of which is increased by examination.

*June 1.*—Patient in inclined plane position. Abdominal section. The right ovary is somewhat cystic; the right Fallopian tube is inflamed, swollen and closed at the abdominal extremity; no trace of fimbriæ. Both are removed, and the abdomen closed without drainage.

*June 13.*—Sickness persisted until the 5th day. Temperature has never been above 99.2°. Pulse has ranged from 58 to 100. Respirations 23 to 26. Primary union of wound found on 6th, when dressings were first changed. Bowels moved on 3rd day, after enema. Flatus passed first on 2nd. Discharged well on 25th.

CASE 6.—Mrs. C., aged 29. Admitted to private hospital January 17, 1898, sent by Dr. Harburn, of Buxton. Married three years. No children or miscarriages. Has always been in poor health. Had "slow fever" at 12 years of age, and did not fully recover from this until 20 years old. Has suffered from anæmia. Menstruation started at 13, but with intervals of three to six months. Was not regular until she went to Buxton seven years ago. From that time had fair health, until six months after marriage, when she had "swelling of the ovary." In October of that year, 1895, had scarlet fever. Was in sanatorium for seven weeks. After this was much better than ever before.

Ten months ago, being in Blackpool, she caught a chill just when her monthly period was expected. This came on, but was scanty and clotted, but without much pain. Five weeks

after had another period, the discharge of which was dark and mixed with clots. Has seen nothing since. During the first three months of her illness had severe continuous pain; since that time this has been intermittent, but is quite as severe when it recurs. For the last nine months has suffered from night sweats. As far as can be ascertained there is no tuberculous history in the family. Father is living, aged 70. Mother died of typhoid.

Began to lose flesh about a month after onset. Last February she improved sufficiently to go to Southport, but quickly relapsed, and with the exception of a few hours each day at that time she has spent the last ten months in bed. Is greatly emaciated. Eyes bright, cheeks hollow, nails not clubbed. The left leg is swollen and flexed upon abdomen. Abdomen generally clear on percussion. Spleen not enlarged. The liver dulness, however, extends  $1\frac{1}{2}$  in. below the line of the ribs. Per vaginam, a firm, elastic, rounded mass is felt behind and on both sides of the uterus, which is fixed. The rectum is full of hard fæcal masses.

20th.—Four grain doses of calomel, given on the 18th, caused much pain, and produced several free evacuations. The patient is somewhat exhausted by this, but is taking food well. Hypodermic injections of strychnia were used on the 19th and repeated this morning. Patient in lithotomy position. Very narrow vagina. Douglas' pouch opened; this gave exit to about 2 oz. of foul-smelling pus. After separating off the bladder the uterus was split completely, but it was impossible to draw either half down, so the vagina was plugged and the patient placed in the Trendelenberg position. On opening the abdomen in the median line a loop of small intestine was found adherent to the bladder and the left iliac fossa. The uterus and left Fallopian tube were shut in by this. The adhesions required division by the scissors, leaving a narrow longitudinal raw surface on the intestine. After this was separated the divided uterus was seen and drawn upwards a little, but it was still so firmly fixed that it would not move much. A large pus sac was now visible on the left side. This was enucleated, but tore slightly, fluid escaping on a flat sponge placed beneath. After removal of the left half of the uterus, with this sac, the right uterine segment was eliminated with comparative ease. The right ovary was discovered after some

search embedded in adhesions and lying over the right psoas muscle, apparently entirely separate from its tube. It was entirely caseous, with a central softened cavity. The whole pelvic cavity was dried out, all vessels tied with silk ligatures the ends of which were cut short. An iodoform gauze drain was drawn through into the vagina, and there being a large area of raw surface in the pelvis, its upper end was so placed as to drain this. The abdominal wall was closed. During the operation the patient showed signs of collapse. Hypodermic injections of supra-renal extract and saline transfusion were used with good effect; but the last steps of the operation were necessarily somewhat hurried. At the conclusion there was no pulse at the wrist, and on return to bed saline transfusion was repeated under the left breast; another hypodermic of supra-renal extract was also given. The pulse again became perceptible, and there was some return of colour in the lips. The foot of the bed was raised high and stimulant enemata (brandy and bovril) were given. Operation over at 12.45 a.m. At 5 p.m. the pulse was very quick and running, the face was cold, the patient restless. There had been free oozing of serum from the vaginal drain. Great thirst, but not much vomiting. As she complained greatly of pain in the back and begged to be turned, she was gently lifted towards her right side, but she immediately complained of great pain and desired to return. The pain did not last many minutes. A morphia suppository gr.  $\frac{1}{4}$  was used and a hypodermic of strychnia given. 7 p.m. less pain and restlessness. More reaction. Face not so cold and skin moist. Pulse still soft and running. Had had three nutrient enemata and retained them. To have hot water in small quantities, then peptonised milk and bovril. Temperature 97.5°.

21st.—Better up to 8 a.m., when vomiting commenced. Has passed urine normally. Has had no sleep, but has been fairly quiet. Complains greatly of pain in lower part of abdomen. Pulse extremely thin. Face very hollow. Eyes, however, bright and pupils normal. Enemata tend to return. Strychnia hypodermics every four hours. Face is not cold and feet fairly warm. Lies on back with her legs drawn up. Is practically mere skin and bone. 2 p.m., sudden collapse, with cold face, sweating, cold extremities, insensible pupils, transfusion under both breasts, death.

It will be noted that even if we had contented ourselves



with vaginal incision and drainage the right ovary would still have been left, as it was impossible, even after the abdomen had been opened and its position located to reach it with any instrument introduced through the vagina.

CASE 7.—Mrs. B., aged 31. Sent into private hospital by Dr. O'Doherty, May 4, 1898. Married nine years; no miscarriages or confinements. Menstruation commenced at 14 years of age; was ill with typhoid fever at the time. All periods have been attended by pain, generally lasting for one or two days after, and worse at this time, not sufficient, however, to keep her in bed. Has always been regular every three to four weeks. Present discomfort began about eleven years ago, with pain in the left lower quadrant of the abdomen. This has steadily become more frequent and more intense. It has lately attacked her about every fortnight. It passes down the left leg in the course of the anterior crural nerve. There has been some leucorrhœa, but this has never been profuse at any one time, nor has it been associated with any smarting during urination.

May 6.—Abdominal section in the inclined plane position. On opening the peritoneum the omentum was found adherent to the uterus and to the left Fallopian tube. These adhesions were easily separated. Both tubes were found swollen, reddened and occluded, the left tube being coiled inwards and downwards around the ovary, with which it formed a tubo-ovarian abscess. All were adherent in Douglas' pouch to the uterus and their respective broad ligaments. As both wife and husband were extremely anxious that, if possible, one ovary and tube should be left, as the pain had always been limited to the left side, and as it seemed just possible that the right tube might recover, it was left, whilst the other was enucleated. During removal some of the fluid, a thin, brownish, purulent material, escaped, but was caught on sponges packed around. After removal the stump of the tube was sewn over. The abdomen was closed without drainage and sealed by celloidin. The usual after-treatment was adopted, calomel being used freely, and the patient recovered perfectly without a bad symptom.

CASE 8.—M. C., aged 43, admitted into Ancoats Hospital April 3, 1899. Menstruation commenced at 18 years of age, and was regular up to the birth of her only child, 21 years since. This child died of phthisis when 6 years old. Patient

has never been well since. No miscarriages. Menstruated regularly every month during lactation and since. Two years ago she first noticed a mass in the right iliac fossa. This was accompanied by pain and some vomiting. She had lost flesh for about a year before. There had been no injury or any other known cause. On the right side at the present time is a rounded mass about the size of an orange, dull on percussion, with a clear area between it and Poupart's ligament on the same side—apparently, on bimanual examination, continuous with the uterus.

*April 11.*—Patient in Trendelenberg position. Abdominal section in median line. On opening the peritoneum the omentum is found firmly adherent over a large convoluted mass, which proves to be the right Fallopian tube; its surface greatly resembles that of inflamed intestine, and it is adherent to the brim of the true pelvis and fascia over the psoas muscle. On separating the omental adhesion, pus gushed out. This was caught upon sponges, and the tube enucleated as quickly as possible. The abdomen was washed out with saline solution, which was dried out with sponges, then closed in the usual way without drainage. 10 p.m., temperature  $102^{\circ}$ . Urine passed naturally at 11:30 p.m.

*April 12.*—10 a.m., temperature  $101.6^{\circ}$ , pulse 124, respiration 32; 2 p.m., temperature  $102.8^{\circ}$ , pulse 136, respiration 36; 6 p.m., temperature  $101.2$ , pulse 100, respiration 32. Calomel gr. i. hourly for six doses. Bowels moved twice 5-6 p.m. First two stools were offensive.

*April 13.*—10 a.m., temperature  $102^{\circ}$ , pulse 100, respiration 28; 2 p.m., temperature  $100.4^{\circ}$ , pulse 100, respiration 28.

*April 15.*—Temperature  $99.4^{\circ}$ , pulse 100, respiration 26. Bowels have been moved once daily; has had some coughing since taking the anæsthetic (Æther). There is a slight bloody discharge from the vagina which commenced yesterday.

*May 19.*—Discharged well.

CASE 9.—M. W., aged 33, admitted Ancoats Hospital October 23, 1899. Married 11 years. No children or (miscarriages?). Menstruation commenced at the age of 13; has been regular up to the present time. Loss at periods has always been rather profuse and mixed with clots. Since marriage, in addition, "lumps of flesh" have passed also. There is always pain at first over the sacral region, but since

marriage this has become less. For the last eight years there has been more pain in the hypogastrium, at first mainly on the right side, but during the last few months this has changed to the left side. The last period, commencing October 18, has been more profuse than usual. Has lost flesh lately. Used to be very stout. During her life she has had three "floodings"—the first seven years ago, which lasted three weeks; the second, four years ago, lasted one week; the last, in December, 1898 lasted only a few days, but was very profuse during that time. Has never been well since. Has been treated by drugs, and pessaries for retroflexion. Bimanual examination shows an enlarged uterus, hard, immovable, with a swelling extending on both sides and posteriorly.

*October 27.*—Patient in Trendelenberg position. Median abdominal section. Uterus very firmly fixed; on the left side a large pyosalpinx adherent to the broad ligament; on the right an inflamed distended tube, with closed fimbriæ, adherent to small intestine. Uterus and both appendages removed. When all was cleared away, a large, raw, ragged surface was left in Douglas' pouch. As the patient showed signs of exhaustion, iodoform gauze was drawn through into the vagina—the upper end being allowed to protrude into the peritoneal cavity—no attempt being made to close the pelvic peritoneum. The abdominal wall was closed by tier suture, but was not sealed, because, in removing the left tube, some of its contents came in contact with the edges of the abdominal wound. A strychnia hypodermic was given during the operation. Shock was marked for a couple of hours, but there was no particular pain or restlessness. During the first and second day there was some sickness, but this ceased on the third, and did not return. Calomel gr. i. every hour for seven doses, commenced nine hours after operation. Urine passed naturally thirteen hours after operation, and regularly afterwards. Flatus first passed in twenty-four hours, then freely. On the second day a terebinthinate enema was given, followed by one ounce of sulphate of magnesia. On the third day the bowels acted freely. Recovery was checked by some suppuration around one or two of the abdominal deep sutures, but otherwise was complete.

CASE 10.—S. A. O'L., aged 28, married seven years. Admitted January 18, 1900, under Dr. Williamson. Transferred

to surgical side January 24. No children or miscarriages. Menstruation somewhat irregular; five weeks' interval at times. No pain or illness after marriage, no profuse leucorrhœa; smarting on urination, &c. Husband said to be healthy. Has been ill fourteen days; pain came on suddenly in right iliac fossa, with vomiting, both of which have steadily increased. Patient is stout, with a healthy colour; lies on back, with both knees acutely flexed; complains of intense pain in the lower abdomen, worst on the right side. The entire abdomen is tender to touch, especially on the right side, below McBurney's point. There is irregular distension, with the sensation of a firm rounded mass, which extends from the right inguinal region to beyond the umbilicus and median line. This is dull on percussion. Temperature 102°.

*January 24.*—Trendelenberg position. Median incision from pubis to above umbilicus. The omentum is found firmly adherent to a tense, fluctuant tumour. Omentum tied and divided; mass turned out. Whilst doing this, thin ichorous pus spirted out in quantity from a point low down on the outside. This proved later to be the outer extremity of a greatly dilated left Fallopian tube, which had been plugged by thickened omentum, and the adhesions of which yielded on slight traction. Sponges were packed in, and the sac allowed to empty itself; then the uterine attachment was divided, and the separation and enucleation commenced from this side. The uterus was of normal size. The mass consisted of the left tube and ovary, converted into an abscess sac, bent upon itself and upon the uterus, so as to lie behind it, and the right broad ligament, to both of which it was closely and firmly adherent. Still further to the right and below was a fluctuant elongated mass, about the size of small intestine, which was connected with the parts around by numerous adhesions, some short and close, others membranous in character. Many long adhesions were connected to bowel, uterus, and other organs. These were all tied and removed with the mass which resolved itself into the right tube and a cystic ovary. The abdominal cavity was dried out and closed in the ordinary way. Celloidin, however, was not used, and a small drain was placed in the subcutaneous tissue, as it was pretty certain that some of the tubal contents had infected the wound. It is very doubtful whether all pus was prevented from soiling the peritoneum itself. A



good deal of fouled omentum was removed. Operation finished about 6 p.m. Afterwards she was very restless and in some pain. Vomited at 12 p.m. Three grains of calomel were given at 1 a.m. on the 25th, and repeated each hour for three doses. At 2 a.m. (January 25) temperature was  $97^{\circ}$ , pulse 104, respiration 30; at 3.30 a.m. a hypodermic of morphia gr.  $\frac{1}{4}$  was given; 5.25 a.m., urine passed naturally (twelve ounces); 1.10 p.m., bowels slightly moved, temperature  $97.8^{\circ}$ , pulse 104, respiration 28.

*January 26.*—Hiccough lasting thirty-six hours; not severe. 6 a.m., some discharge of blood per vaginam lasting twenty-four hours; 12 noon, subcutaneous drainage tube removed; 7 p.m., some cough and expectoration. This continued for about three weeks.

*January 27.*—11.30 a.m., calomel gr. v., followed by free stool.

*February 4.*—Three skin sutures have given way; some suppuration in abdominal wound.

*February 23.*—Is rather melancholic; lies very low in bed; begins to complain of pain over the hepatic flexure. It has always been difficult to keep the bowels acting. This, she says, has always been the case. There is no true rigidity of the abdominal walls, but a sensation as of hard masses in the colon. A rectal examination shows the presence there of similar fæcal concretions. Five grains of calomel, followed by oil enema, and, later, soap and water, brought away these and produced free evacuations, with the result that the pain disappeared for about three days—though increased resistance over the hepatic flexure still remained. The pain returned on March 1, on which day the temperature was  $100^{\circ}$ . After this time it became very irregular. The mass appeared to travel nearer to the middle line, and became very tender. There was general tenderness over the lower edge of the ribs on the right side extending into the epigastrium. Nothing could be felt in the pelvis.

*March 16.*—The mass having become prominent in the right hypochondrium, tense, and very painful, a vertical incision was made over this point. Pus escaped in large quantity. The finger passed into a cavity of which the floor was the right lobe of the liver. This cavity was washed out with saline solution, and a large drainage tube inserted. After

this evacuation the temperature fell to normal, the cavity pretty rapidly closed, and the patient left the hospital April 30 with a small sinus at the point of drainage.

These cases, it will be seen, have been selected from a much larger number, because they are mostly severe, and therefore illustrate the conditions for which the surgeon should be prepared who proposes to attack a case of pyosalpinx by the abdominal route. They also show, I think, the impossibility of radical cure of such lesions by the vaginal method. Even in Case 6, to which I referred at starting, it would have been imperative later to resort to abdominal section if only to remove the degenerating right ovary, which, as long as it remained, would have prevented complete and sound recovery, and which was absolutely inaccessible from the vagina. Of course, the skill of different operators varies within wide limits, and it would be rash to say that what is impossible for one may not be possible to another; still, it is important that the parts should be left as free from bruising as possible; and it will be obvious that the risk of this is largely increased in such cases as I have described if all the necessary manipulations are carried out through so small and rigid a passage as the vagina in women of adult age who have never born a child.

But, above all, these cases, I conceive, show forcibly how much may safely be trusted to the unhampered peritoneum, even after very serious operative disturbance, and endorse fully the doctrine that the abdominal glass drainage tube is not only useless but directly harmful, and should be relegated to the list of the appliances which are now obsolete.

## REVIEWS.

CANCER OF THE UTERUS—ITS PATHOLOGY, SYMPTOMATOLOGY, DIAGNOSIS AND TREATMENT; ALSO THE PATHOLOGY OF DISEASES OF THE ENDOMETRIUM. By THOMAS S. CULLEN, M.B. (Toronto); Associate Professor of Gynæcology in the Johns Hopkins University. With 11 lithographic plates and over 300 coloured and black illustrations in the text; pp. xvi. and 709; 4to. London: Henry Kimpton, 1900.

The amount of labour which Dr. Cullen and his assistants have expended on the work before us must have been very great, and the result of their toil is of commensurate importance. The author has produced a work which traces cancer of the uterus, in all its various forms, from its onset to the time at which its extensions and metastases became so numerous that a fatal result occurred. And not only are the symptoms, diagnosis, pathology, complications, and treatment of the various forms in which the disease attacks the uterus given *in extenso*, but many hundred illustrative cases are similarly described. As regards the illustrations with which the work is lavishly supplied, it is sufficient to say that they have been drawn by the skilful draughtsmen who illustrated Kelly's "Operative Gynæcology," and that they are equal in every respect to the drawings in the latter work. The reproductions of microscopical specimens are particularly beautiful.

We cannot, however, think that Dr. Cullen has succeeded in carrying out the aim which he has set himself in the preface. The work before us will be of the greatest interest and use to the specialist who treats the cases it

describes, or to the pathologist who seeks help in tracing the origin or the varieties of uterine cancer. But to the "general practitioner who, as a rule, is first consulted," or to the family physician to whom Dr. Cullen wishes to give "a clear idea of the early signs of carcinoma in order that he may always be on his guard, and may not treat too lightly any suspicious indications which may be present," the work will be—if such an expression is permissible—somewhat of a white elephant. It is too large, it is too minute, and it is rendered too confused by the immense number of illustrative cases with which its descriptions of diseases are commingled, to enable a busy searcher after concise information to glean even a fraction of the information with which the work is capable of supplying him.

We do not for a moment wish to convey an unfavourable impression of Dr. Cullen's work. It is true that in our opinion it will not hit the target at which it is aimed, as it has been given too high a trajectory. It will, however, reach a more distant mark, and one which it requires a far more experienced marksman to hit.

It is from the point of view that the book is intended for specialists that we prefer to criticise it, and here there can be no divergence of opinion. The work is one of the finest—if not the finest—monograph on the subject which has yet been published. The anatomical relations of the uterus and adnexæ, the available means of early diagnosis, symptoms, treatment, and microscopical and macroscopical pathology, are all treated in the greatest detail.

Dr. Cullen has done much to introduce to this hemisphere the latest, and so far as we can judge, the best form of hysterectomy in cases of malignant disease of the uterus. At the XIII. Congrès International des Sciences Médicales, held at Paris last year, he read an article on Werder's (of Pittsburg) "New Operation for the Radical Treatment of Cancer of the Cervix," and in the volume before us he fully describes and illustrates it. The operation appears to us to so well deserve publicity that we



make no apology for reproducing Dr. Cullen's words :-- "Werder opens the abdomen and frees the uterus, tubes, and ovaries, as in ordinary hysterectomy; he then dissects out the ureters, and controls the uterine arteries near their sources of origin. The bladder is entirely freed not only from the uterus but also from the vagina for a considerable distance. The recto-vaginal space is then opened, and the posterior vaginal wall is stripped from the rectum as far down as necessary. Finally the lateral attachments are loosened. The uterus and the vagina having been thus entirely freed, the uterus can be pushed down into the pelvic outlet, the vagina being inverted by making traction from below. The peritoneum from the anterior pelvic wall is united with that covering the rectum, and the abdomen is closed. The vaginal vault is now ringed, and the uterus, together with a vaginal cuff of the desired size, is removed. All this can be done without touching the diseased cervix with the fingers, or allowing it to come in contact with any wound surface, thereby absolutely excluding the possibility of inoculating healthy tissue with cancer elements." Should this operation prove to be as easy of execution as Dr. Cullen's description would lead one to think, it will undoubtedly constitute an important step forward in the operative treatment of malignant disease of the cervix. It enables the retro-peritoneal glands to be reached and removed—should such a procedure be deemed necessary. It renders it possible to take away almost the entire vaginal mucous membrane and sub-mucous tissue, and it provides the most efficient method of preventing the inoculation of cut surfaces by the malignant growth.

One disadvantage in the operation will strike most people. If in vaginal hysterectomy it is found to be impossible to proceed, owing to the advanced condition of the growth, it is easy to retrace our steps, as difficulties most usually are met with at the commencement. In Werder's operation, on the other hand, the impossibility of the operation may not be discovered until the abdomen has been

opened and the superior attachments of the uterus divided—a serious proceeding if not accompanied by any compensatory advantage.

The author does not enter very closely into the ætiology of so-called "*deciduoma malignum*." A more extended review of the various theories which have been brought forward to explain its origin might have been given. For instance, Veit's view of the nature of the growth has been omitted, although it is one which many authorities share. If the author had brought forward a definite theory which he was prepared to support, such an omission could be accounted for, as throughout the work he refrains from multiplying theories or practices which he does not agree with or follow. He has not however in this case advanced any such theory, and consequently the omission of Veit's views is the more noticeable.

There is a short but most interesting chapter on the question of the extension of cancer of the cervix to the body of the uterus and *vice-versâ*. There is no room for reasonable doubt that such an occurrence can take place. Pfannenstiel, Abel, Ruge, Hofmeier and Seelig, have all recorded cases in which squamous-celled carcinoma and adeno-carcinoma of the cervix co-existed with similar growths in the body. In Seelig's case there was obvious squamous-celled carcinoma of the cervix, and though to the naked eye the body of the uterus appeared to be free, on histological examination there were carcinomatous masses in the peri-vascular lymph vessels in the muscle of the body. To this case the author adds another: "There was adeno-carcinoma of the cervix, while from the appearance of the uterine cavity one would not for a moment have suspected that the body was implicated. Histological study, however, showed the uterus to be studded with neoplasms." We may perhaps be permitted to express the hope that this chapter will be closely studied by the few remaining operators who continue to assert that amputation of the cervix is a sufficient operation in cases of malignant disease of that part.

The last chapters of the book are taken up by the question of the ætiology of carcinoma, and in it the author gives the result of his own experience and the experience of the Johns Hopkins Hospital at some length. The conclusions he arrives at leave, as he himself confesses, the ætiology of carcinoma an unsettled question. "The view . . . . that cancer is primarily a disease of the epithelium, is gradually gaining ground, and is undoubtedly correct. . . . Summing up the various analyses as to the causation of carcinoma, we find that heredity seems to have little influence; trauma, as produced by parturition, apparently bears a causal relation to cancer of the cervix, but not to that of the body. Neither the theory of Cohnheim or that of Ribbert explain its origin, and the weight of evidence is against the parasitic theory."

It would have been a fitting close to a century which has seen the birth and lustre of the discoveries of Lister, Simpson, and Pasteur, if Dr. Cullen, instead of ending his work by dwelling on our ignorance of the cause of this terrible malady, had been able to commence it by laying before his readers those essentials which will alone enable a final cure to be obtained in the majority of cases. But in spite of the enormous amount of work which is being done to this end through the civilised world, a more effective line of treatment than the knife has not yet been discovered. That the century which has just dawned will bring such a cure in its train we can have little doubt, and it will be a cure not the result of empiricism, but the direct consequence of the determination of the ætiological factors of the disease. When such a determination is reached, though one or two men may obtain the final credit of elucidation, all those who by pathological or clinical examination or experiment have added to our knowledge on the subject, will be conscious that without their collective aid the task would have been impossible. We may say, without fear of contradiction, that to this determination Dr. Cullen will, by the volume before us, have brought assistance of a most

important kind—the assistance of the man who brings clinical facts and pathological examination into their necessary juxtaposition.

H. J.

UTERINE TUMOURS : THEIR PATHOLOGY AND TREATMENT

By W. ROGER WILLIAMS, F.R.C.S. Pp. xvi. and 360 with 58 illustrations. Demy 8vo. London : Baillière, Tyndall & Cox, 1901. Price 10s 6d. nett.

That this, from its title, should be a valuable and important work there can be no doubt. A glance at its contents is sufficient to establish that it is so. It deals with the varieties of uterine neoplasms, their relative frequency, the development and life history of the uterus, its anatomy, and its histological relation to its neoplastic pathogeny. Myoma of the uterus is considered pathogenetically, morphologically and biologically. Its complications, relations to malignancy, and its general pathology are fully entered into. The clinical features of myoma, and its treatment, radical and palliative, are discussed. One hundred and eighty-two pages of the work are devoted to the consideration of these subjects, with a short chapter dealing with non-malignant tumours other than myoma. The remaining hundred and fifty-six pages are devoted to uterine cancer and the differentiation of the various types of sarcoma of the uterus and decidual sarcoma.

A monograph has to be regarded from a different standpoint to a treatise or text book. Its special claim for favourable recognition and a place on the book shelf rests, firstly, on the clearness and lucidity, as well as comprehensive exposition, with which it handles the particular section of the subject dealt with ; secondly, being a monograph we expect from the author either evidence of special work which he has done in the branch in question, or original suggestions which such work entitles him to offer.

We consider that Mr. Roger Williams may fairly claim



in the work before us to have justified completely his position in regard to the first of these qualifications, and throughout its pages there is ample evidence of painstaking investigation, as well as careful research, which fairly entitles him to place a critical analysis of the labours of others before the profession in a most readable and instructive manner.

It is in the statistical, etiological and histological portions of the work that the personal equation is more prominently in evidence. Necessarily, the greater part of it is a compilation from other authors, and the illustrations are, many of them, those with which we are familiar in the pages of other treatises and text books. From the statistics collected in the London hospitals, the analyses of Gurlt and Schröder, and that of the Registrar-General's returns, the much greater proportion of neoplasms of the uterus than those of any other organ is established. From the statistics mentioned, those collected by himself, and the mortality returns of Frankfort-on-Maine, the author arrives at the conclusion that the proportion of malignant to benign neoplasms of the womb is 59·38 per cent. of the former, to 40·62 per cent. of the latter. There is a clear and well written chapter on the development and life history of the uterus, and another on its histology, in which the opinion is expressed that most sarcomata of the uterine wall arise from cellular elements of the peri-vascular connective tissue of the small blood vessels. Having discussed the question of the pathogenesis of myoma, from the points of view of the cell and germ theory, and entered into the bearing which the various histological complications of myoma have on the elucidation of the question, he says :—" It has been clearly established that the genesis of uterine myomata is connected with the abnormal development of the musculature, detached fragments of which—grouped around heterotopic epithelial 'rests'—are the germs whence these tumours arise ; and it is noteworthy that such formations are chiefly found in the immediate vicinity of the small arteries, which is just the place where myomata generally originate (Kleinwachter,

Rosger, Keiffer, &c.). The morphology and biology of myoma, and the various degenerative changes and sequences, are discussed tersely and practically. These chapters, including that on the question of the origin of malignant from myomatous tumours, have a special significance just at present when the question of the indications for interference by hysterectomy is being so energetically discussed. Not that we believe that statistics which include cases of which the complete histories have not been ascertained are of much importance. We quite agree with the author's conclusion that the experience of most authorities proves that malignant degeneration of a myoma, whether carcinoma or sarcoma, is extremely rare, whereas carcinoma as a complication of myoma is not so. The author, founding his conclusions on the reports of the Registrar-General, considers that the mortality of myoma for the whole community is somewhere about 1 in 2,000, and that it may be considerably lower. We should be sorry to base any conclusions from reports of the Registrar-General which would have a serious bearing on our views as to the relative mortality from pelvic and uterine diseases in women as compared with other causes of death.

The number of cases in which death is commonly assigned to peritonitis, whether general or pelvic, or to other causes, such as appendicitis, pelvic abscess, septicæmia, and tuberculosis, where the real cause is due to primary disease in the adnexæ, either ovary or tube, and such secondary consequences as pelvic peritonitis, pelvic suppurations, vesical and bowel complications or hæmorrhage, must be very large. The same is true with regard to the uterus, it being a fact of every-day experience that various affections of this organ are overlooked in the presence of some more active disease elsewhere, which has diverted suspicion from a cause which may have had a large share in predisposing to conditions which lower vitality, interfere with the general health, and

must seriously complicate the chances of recovery when other organs are affected. Besides, clinically, we are most concerned not with the women, be the number ever so great, who are affected by a myoma which is harmless and not dangerous to life, but with those in whom the clinical signs and symptoms force them to seek the surgeon's advice, and compel him to assume the responsibility as between advising the risk of expectancy and that involved by operation. The absurdity of drawing any inference from the author's argument, that if the practice of some surgeons in removing myomata "whenever recognisable" were generally followed, a million operations of this kind might be done annually, and that thus a hundred thousand would be sacrificed in a single year, is so obvious that it requires no comment. Who are the surgeons who remove a myoma whenever recognisable? We have never heard of one. Still, the author at his own estimate acknowledges that if the disease be left to its natural course five hundred lives are lost annually.

There are several other questions touched on with regard to this subject by the author, which, to say the least of them, are open to discussion. A man's views with regard to operative gynæcology, and the justification for operative interference, are largely influenced by his personal sense of his ability to deal with any particular case that presents itself to him, and by his capacity to appreciate the responsibility he assumes in advising the expectant course and waiting upon danger, or dealing with the case from the truly surgical point of view of deciding the issue purely and simply on the relative risks of interference and non-interference.

Whatever may be the responsibility assumed by a surgeon who feels that his duty to his patient calls for operation, even in the face of grave difficulties and unfavourable complications, and who, believing in his capacity to deal with these successfully, advises operation; that of the man who hesitates, temporises, recommends

a policy of expectancy, and talks of expediency when it is certain that nothing save operation can rescue the woman from conditions incompatible with either her comfort or health, is infinitely greater.

There is not much to remark upon in the portion of the work devoted to uterine cancer. Again, it is in the statistical and etiological portions that we find any valuable contribution to the subject, and the author's views on these matters are already well known through his previous papers on the subject. We are pleased to see that he does not in this instance range himself on the side of those who would temporise with this disease. We do not agree with him as to the complete harmlessness of lacerations of the cervix in relation to cancer, as we have seen well marked instances in which laceration with other complications of the cervix, such as erosion and follicular degeneration, has been the precursor of the carcinomatous change. We do not generally regard vaginal hysterectomy as a "palliative" operation. Certainly, in the great majority of instances, vaginal panhysterectomy is the radical step which is that of selection for carcinoma.

With regard to the operative portions of the work, we have only to say that modern gynæcological technique in operative procedures is of that character that it should be so described in detail, and with such accurate precision as to be of practical value to the operator, or omitted altogether from a work of this nature. To treat in a flimsy, imperfect manner the preparation for, and the steps of the operation itself, its complications and after consequences, in the case of such important an operative procedure as hysterectomy or panhysterectomy for myoma or carcinoma, merely for the purpose of appearing to complete the subject, is vexatious to the educated, and misleading, if not dangerous, to the inexperienced surgeon.

That this work is a credit to its author, any one who reads its pages will recognise. It will confirm the reputation he has already gained as a painstaking and discriminat-



ing observer, and side by side with his monograph on "Diseases of the Breast," it forms a valuable addition to the library whether of the gynæcologist or the general surgeon.

H. M.-J.

**ELECTRICITY IN GYNÆCOLOGY.** By RICHARD J. COWEN, L.R.C.S.I., L.R.C.P.I., &c. Crown 8vo. Pp. 132, with 36 illustrations. London : Baillière, Tindall & Cox. Price 3s. 6d. net.

To anyone acquainted with the degree to which electrical methods of treatment are now being advantageously employed in the diseases of women, it must be an interesting question why these methods were so long in finding favour with the medical profession. We agree with the author of this little book that this has been due to a want of literature dealing with the practical details. He also goes so far as to say that the faradic coil, valuable as it is in its proper place, did much to retard the recognition of the true importance of electrical therapeutics, especially of galvanism ; the apparent simplicity of the faradic machine made it popular, and it was employed in many unsuitable cases, and to the exclusion of other means that would have been more effective. Even now the suggestion of electrical treatment usually conveys to the patient the idea of shocks from a faradic machine.

But the unwillingness of the public, and still more that of the medical profession, to adopt electrical methods in dealing with disease, may rather be attributed to the scope these methods offer to the charlatan, and to the way they had been commercially exploited by unqualified and unscrupulous advertisers. Moreover practitioners were naturally averse to attribute much value to methods that, very often without trial, had met with condemnation from some of the most eminent of their colleagues ; of Apostoli's treatment for fibroids one such writes, "Hitherto we have not tried it ; tedious and painful, and uncertain in its results, it has often been followed by rigors and a pyrexia as high as 40° C., and several untoward experiences recently recorded

will now deter us from making any trial of it." No doubt electricity, like nearly every new treatment, was improperly practised by its earlier partisans, not only by the use of excessively strong currents or too prolonged applications, but also by employing it in cases in which it was not merely useless but harmful.

Few novel modes of dealing with disease force their way to final recognition without serious mistakes during what our German colleagues appropriately call the "*Lehrzeit*." Happily the worst of this experimental period as regards electrical therapeutics is over, and we have learned to know the class of cases in which it may be relied on to relieve pain, control hæmorrhage and congestion, or diminish the size of an enlarged uterus or myomatous tumour; and when the indications for more radical interference are not imperative, the accumulated evidence of thirty years as to its effects in securing at least a symptomatic cure, fully warrant us in resorting to electricity before operating, and especially so in patients who are near their climacteric.

We therefore welcome this introduction to the practical details of electrical therapeutics. Time and patience are required both by patient and physician during a course of treatment, but with the precautions here laid down, careful selection of cases, rigid asepsis, the use of currents of moderate strength gradually raised to their maxima, and as gradually lowered before being cut off, the avoidance of the negative pole internally when there is any tendency to hæmorrhage, &c., no careful man need anticipate any serious mishap.

Writing specially for practitioners the author has endeavoured to abstain from technicalities, but omelettes cannot be made without breaking eggs, nor can electricity be discussed without technical terms. Of these a concise glossary would have been welcome. For information of this kind we can with confidence recommend the excellent pamphlet, now in its seventh edition, issued by Mr. Schall of Wigmore Street.

PUBLICATIONS RECEIVED.

Pressure on our space compels us to postpone more particular notice of the following publications :—

Transactions of the American Association of Obstetricians and Gynæcologists, vol. xii., 1900.

Transactions of the Section on Gynæcology of the College of Physicians of Philadelphia, vol. v., 1899.

Transactions of the American Gynæcological Society, vol. xxv.

FROM THE UNIVERSITY OF TORONTO :

- (1) The Anatomy of the Orang Outang. By A. Primrose.
- (2) The Structure, Microchemistry, and Development of Nerve Cells, with special reference to their Nuclein Compounds. By F. H. Scott.
- (3) The Cytology of Non-nucleated Organisms. By A. B. Macallum.
- (4) The Gametophyte of *Botrychium virginianum*. By E. C. Jeffrey.

FROM JOHN BALE, SONS AND DANIELSSON :

- (1) A Prescriber's Companion. By Thomas D. Savill. Third Edition.
- (2) Outlines for Dissectors. By F. G. Parsons, F.R.C.S., Examiner in Anatomy for the Fellowship of the Royal College of Surgeons of England. Parts II.-V. 1s. 6d. each.
- (3) The British Sanatoria Annual, 1901.

FROM BAILLIÈRE, TYNDALL AND COX :

- Electricity in Gynæcology. By R. J. Cowen, L.R.C.S.I., &c.  
The History of Ancient Gynæcology. By W. J. Stewart McKay, M.D.

FROM W. B. SAUNDERS AND CO. :

- (1) Atlas and Epitome of Gynæcology. By Dr. Oscar Schaeffer.
- (2) Obstetrics. By Barton C. Hirst, M.D.

Braithwaite's Retrospect of Medicine, vol. cxxii., 1900.

Frommel's Jahresbericht ueber die Fortschritte auf dem Gebiete der Geburtshilfe und Gynækologie, vol. xiii., 1900.

Anleitung zur Diagnose und Therapie der Kehlopf-, Nasen-, und Ohrenkrankheiten. Von Dr. Richard Kayser, in Breslau. Berlin, 1901 : Williams and Norgate.

Ureterfisteln und Ureterverletzungen. Von Dr. W. Stoeckel, in Bonn. Leipzig : Breitkopf und Haertel, 1900.

Vademecum für histopathologische Untersuchungen in der Gynäkologie für Aerzte und Studierende. Von Dr. E. G. Orthmann, in Berlin ; mit 73 Abbildungen. Berlin : S. Karger, 1901.

Report of the Wolverhampton Hospital for Women, 1899.

Merck's Digests, No. 9, Stypticin ; No. 10, Cacodylic Acid and Cacodylates.

And the following reprints :—

- Professor John W. Byers (Belfast): The Prevention and Treatment of Post-partum Hæmorrhage.
- William Duncan, M.D.: (1) The Modern Treatment of Uterine Fibroids; (2) One hundred Consecutive Cases of Abdominal Section in Hospital Practice without a Death.
- Henry Jellett, M.D.: The Dublin Method of Delivering the Placenta.
- Septimus Sunderland, M.D.: Pelvic Pain in Women from Impacted Ureteral Calculi.
- H. J. Boldt, M.D.: The Present Status of Operations for Cancerous Uteri.
- E. B. Cragin, M.D.: The Treatment of Full-term Ectopic Gestation; should not the child receive more consideration?
- Wilmer Krusen, M.D.: (1) Treatment of Uterine Prolapse, with illustrative cases; (2) Conservative Surgical Treatment of Uterine Fibroids; (3) A Case of Thyroidectomy; (4) Sequelæ of Abdominal Operations; (5) Difficult Points in Gynæcological Diagnosis.
- Professeur A. Goubaroff (Moscou): Des Avantages d'opérer sans Hémostase préalable.
- Koblanck: Ueber Störungen der Physiologischen Function der Weiblichen Sexualorgane.
- Dr. Desider Stapler (Brazil): Zur Vaporizations Frage.
- Professor G. Calderini (Bologna): (1) I tumori a sviluppo inter-legamentoso; (2) Sulle indicazioni della operazione cesarea, della sinfisiotomia, della craniotomia e del parto prematuro; (3) Transperitoneale Einpflanzung des Ureters in die Blase behufs Heilung der Ureter-Gebarmutter Fistel.
- Certification and Classification of Diarrhœa Deaths. Reprinted from *Public Health*. Rebmanns.



## QUEEN VICTORIA.

THE following letter and address have been drafted in accordance with the Resolution of the Annual Meeting:—

SIR,—On behalf of the Council and Fellows of the British Gynæcological Society we have the honour to forward to you, for humble submission to His Majesty the King, a loyal and dutiful address of condolence with His Majesty on the lamented death of Her late Majesty Queen Victoria.

We have the honour to be, Sir,

Your obedient Servants,

CHARLES RYALL }  
J. H. SWANTON } *Secretaries.*

To His Majesty's Principal Secretary  
of State for the Home Department.

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*To His Most Excellent Majesty King Edward VII.*

MAY IT PLEASE YOUR MAJESTY,

We, the President and Council of the British Gynæcological Society, the numerous Fellows of which body are resident throughout the entire of Your Majesty's dominions, beg humbly to approach Your Majesty and the other members of the Royal Family, with our heartfelt assurance of profound sympathy and deep condolence at the loss of Your Royal Mother, our late most beloved and venerated Sovereign Lady Queen Victoria.

We desire also to express our earnest hope that Your Majesty, with the blessing of God, may long reign over your loyal and devoted subjects, and we devoutly pray that you and Your Royal Consort, endeared to all Your Majesty's loving subjects throughout the Empire, Her Gracious Majesty Queen Alexandra, may live for many years to come in peace and happiness.

J. A. MANSELL MOULLIN,  
*President.*

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## SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

*Opinions as to pathology or treatment expressed in the following abstracts are not necessarily endorsed by the editors or their collaborators. Any Fellows of the Society who may be willing to give the editor-in-chief regular assistance in the preparation of this summary are requested to communicate with him. He will be greatly obliged by having his attention drawn to any important work published at home or abroad; particularly so by receiving condensed abstracts of such work from the authors themselves.*

### DYSMENORRHŒA.

EDGE (*Birmingham Med. Rev.*, 1900, Feb.) dealing only with dysmenorrhœa in which there is local pain or discomfort, or in which the patient herself connects her trouble with the menstrual function, insists on the importance of determining whether, and in what way, the ovary, tubes or uterus is in fault, and in case of the uterus, whether the mischief is developmental, mechanical or inflammatory. Apart from the appropriate treatment of local diseased conditions, he lays much stress on attention to the alimentary canal, salines, fresh air, exercise, and plenty of hot water, with massage and tonics in neurotic cases, and he attributes the benefits of Ems, Woodhall Spa, and other watering places in great measure to the free use of these means of treatment.

### MENOPAUSE.

VIRSCH, Prague, Marienbad (*Leits. f. diät. u. physikal. Therapie.*, Bd. iii., Heft 8), eulogises the effects of proper diet upon the troubles of the menopause, due partly to disordered circulation to fluxions and stagnations of blood, and partly to affections of the nervous system with symptoms of slightly disordered sensation, neuralgia, and sometimes psychical disturbance. Over-feeding and stimulants, alcohol or strong tea or coffee, must be entirely avoided. The diet should be non-irritating, and preferentially of a mixed kind; the meals frequent, but not too plentiful, and much water should be drunk; obesity must be

combated by proper regulations. In very severe climacteric troubles a milk diet, not too rigid, is indicated. Warm baths are beneficial by counteracting nervous irritability.

#### ATRESIA.

TOFF, Brailas (*Wiener kl. Wchns.*, 1900, No. 11), records a case of hæmatokolpos and hæmatometra, the result of atresia hymenalis congenita, in a child of 13. The patient appeared to have a round tumour resembling a uterus in the fifth month of pregnancy. The pelvis was filled by a fluctuating mass almost the size of a foetal head, and a dark, reddish brown swelling appeared between the labia. Incision of this allowed the escape of about a litre of dark brown fluid, and under irrigation with warm sublimate solution the girl soon recovered. An aunt of hers had suffered in the same way. Toff attributes atresia not to accidental interference with development, but to more recondite peculiarities of constitution.

#### RETENTION OF MENSTRUAL BLOOD FROM ATRESIA OF THE VAGINA, WITH PRELIMINARY REMARKS ON THE INDICATIONS FOR LOCAL EXAMINATION IN THE DISORDERS OF MENSTRUATION.

CULLINGWORTH (*B. M. J.*, 1900, January 6 and 13) strongly deprecates local examination in cases of dysmenorrhœa, unless there are indications of some definite local obstruction, such as a tumour or cicatricial contraction, or the suffering be very severe and disabling, and the usual treatment has failed to relieve. In the latter case he considers an examination justifiable, either to exclude once for all serious local mischief, or as a preliminary to local treatment, by dilatation of the uterine canal.

In cases of menorrhagia or metrorrhagia, however, local examination should be the rule, uterine hæmorrhage being almost always the result of local lesions. One exception only is made, namely, where hæmorrhage occurs at the onset of menstrual life, since the first period is occasionally alarmingly profuse. Should, however, the hæmorrhage be repeated frequently, or menstruation having been normal become excessive, a thorough internal examination should be made. In this connection is cited the case of a girl, aged 18, who had suffered from menorrhagia for two years, before the cause, a patch of polypoid adenomata of the endometrium, was discovered. For two months prior to examination the discharge had been almost continuous. The same rule holds for hæmorrhages occurring during pregnancy, or abnormal hæmorrhages following abortion or labour.

Varieties of amenorrhœa are next dealt with. Arrested menstruation is usually due either to some obvious disturbance of the general health, or to pregnancy. In the former case



vaginal examination is scarcely ever necessary ; but where there is evidence of pregnancy, and the question cannot be settled by an abdominal examination, a vaginal examination should be made.

In cases of delayed menstruation a vaginal examination should be avoided, unless the occurrence of periodical pains in and round the pelvis, or the presence of a swelling in the lower part of the abdomen, in a patient who has never menstruated, indicates the retention of menstrual blood. If one or both these symptoms be present, a local examination is imperative. A child 13 years of age, under the author's care, had a tumour reaching to the umbilicus, and thirty-one ounces of fluid escaped on an incision being made through the hymen, yet she had complained of no recurring pains. The swelling was due to distension of the vagina, and the uterus took no part in it, but was simply perched on top. No doubt the uterus would have become distended in time, the cervix being already expanded. A diagram shows the effect of this variety of menstrual retention. The vagina is seen to be enormously distended, the uterus elevated, the lower part of the cervical canal expanded, the rectum encroached upon, and the anus dilated. The bladder becomes elongated and compressed, its summit accompanying the uterus in such cases.

Of the four cases given, illustrating menstrual retention, two had no menstrual molimina at all, one had them only for seven weeks, and the only one who had had them for any considerable period was a girl aged 21, who had suffered from them for twelve months.

The treatment practised by Cullingworth is "to thoroughly disinfect the occluding membrane and the parts around, and then with a sterilised knife to make a free incision in the middle line in the axis of the vulvar opening. If the contents of the vagina do not escape freely, the knife may be turned round, so as to separate the edges of the incision, or a cruciform incision may be made."

The fluid is allowed to escape slowly. No pressure is made upon the abdomen. Thus are avoided the risks of sudden and undue strain upon possibly distended tubes, and an inrush of air into the vagina when the pressure is relaxed. No irrigation of the vagina is practised: (1) to avoid the injection of air or germs; (2) owing to its consistence, it is not possible to cleanse all the blood away, and it is therefore better to let it drain naturally into an absorbent pad bound tightly over the vulva.

The patient is kept recumbent for some days, except during meals, when to facilitate drainage she assumes the sitting posture. As soon as the coloured discharge has entirely ceased a dilator is introduced and secured in position. The instructions

given in one case were, that it should be worn for some period of the twenty-four hours for, at least, one year.

H. M. J.

PATHOLOGICAL AMENORRHŒA  
FROM OTHER THAN CONSTITUTIONAL CAUSES.

HAULTAIN (*Edin. Med. Jour.*, 1900, April), including pregnancy and deteriorated constitutional states, divides the causes of amenorrhœa broadly into three classes: (1) atresia of the canals, (2) uterine conditions, (3) ovarian conditions.

He cites cases of atresia, hymenalis and atresia vaginalis, treated successfully by making an exit for the retained fluid and permitting it to escape naturally for forty-eight hours, after which period antiseptic vaginal douching was adopted. As illustrating atresia cervicis, the condition found, at operation, in a girl aged 24 is quoted, viz.: A very rudimentary right uterus unicornus distended with a tarry substance, a considerable quantity of which was also between the layers of the broad ligaments. This rudimentary horn was divided as near the larger left one as possible. The ovaries, which were removed, were enlarged, and contained blood cysts and extravasations indicative of intense congestion. The patient's recovery was uninterrupted. Haultain adds that these cases might be properly described as examples of concealed menstruation, and notes the irregularity of the pain complained of. In one case it was markedly periodic and occurred monthly, and in the others, one of which closely simulated recurrent appendicitis, there was no periodicity, and long intervals separated the paroxysms.

In passing to amenorrhœa due to functional inactivity of the uterus and ovaries, the following facts are emphasised. Well-developed functionally active ovaries may be present without any development of the uterus, and *vice versâ*. The organic developments of both these organs, though usually coincident with, does not necessarily imply, the development of their functional activity, nor of sexual instincts, and conversely, the sexual instincts may be acute in women devoid of functionally active sexual organs. Cases illustrating these conditions are quoted. Where no palpable cause for primitive amenorrhœa exists, it is probably of nervous origin. If amenorrhœa be due primarily to non-development of the ovaries or uterus, organic or functional, or if uterine and ovarian activity cease as the result of the physiological changes normally occurring at the climacteric, then treatment is useless. But if amenorrhœa be originally due to constitutional conditions, and the removal of these conditions be not accompanied by the appearance, or reappearance of menstruation, much may be done, provided the organs show little want of physical development in the one case, and that the continued

inertia has not produced atrophy and secondary incurable changes in the other.

The author disapproves of the haphazard use of the galvanic intra-uterine stem, irrespective of the cause of the disease. If the ovaries appear to be at fault, he administers ovarian extract, if the uterus, he employs a *continuous* electric current of forty to sixty milliampères, the negative pole being inserted into the uterine cavity. The galvanic stem and faradic current he found extremely unsatisfactory, but this success with the constant current warrants its continued trial. His results with ovarian extract have been irregular, but on occasions strikingly successful. That ovarian extract has a beneficial action, in certain instances, after removal of the ovaries, he is convinced from observations on many cases. The dimensions of the uterus indicate the line of treatment to be followed, since defective uterine function, in contradistinction to ovarian inactivity, is usually associated with diminution in the size of the organ. The author entirely refrains from local treatment for amenorrhœa in the unmarried.

H. M. J.

#### THE CLINICAL SIGNIFICANCE OF DEVELOPMENTAL DUPLICATIONS OF THE UTERUS AND VAGINA.

By BROOKS H. WELLS, New York.

*Amer. Jour. Obst.*, 1900, March.

This paper deals fully with the subject, and includes a review of the literature of the past decade, involving a separate brief report of each of 112 cases. The cases are divided into four categories: (1) Cases of double uterus or vagina without complications; (2) cases of retention accidents; (3) cases of pregnancy delivered through the natural passages; (4) cases of pregnancy delivered by abdominal section.

The following definitions have been adhered to. "Uterus septus" means a uterine body with a fundus of normal shape or somewhat broadened, but with an antero-posterior septum dividing its cavity into two; this uterus usually has one cervical opening, but may have two. "Uterus arcuatus" has the middle of the fundus depressed and more or less of a septum. In "Uterus bicornis" the two horns are more or less perfectly separated, but are joined to one cervix. In "Uterus duplex" the two horns are completely separated, and there are two separate cervixes, united at the vaginal junction only by a band of connective tissue. In "Uterus didelphys" the separation is complete. A study of the 112 cases leads the author to the following conclusions:

(1) *Double Uterus or Vagina uncomplicated by Retention Accidents or Pregnancy.*—Women the subjects of this malformation do not necessarily show any other peculiarity dependent on imperfect



development. The condition is usually discovered accidentally while seeking the cause of the dysmenorrhœa or menorrhagia commonly affecting these women. Menstruation may occur from both sides simultaneously, or may alternate on right and left, and is scanty when both horns are poorly developed, but amenorrhœa is exceptional when there is any endometrium present. Uterus septus is probably the most common malformation, but uterus bicornis is most often recognised. Double vagina is easily overlooked, and in many instances has remained undiscovered during many years of married life. When the vagina is double the right one is usually the smaller, and the right uterine horn is more frequently the less well developed. Uterus septus is usually discovered by accident during a curetting or examination with a sound. In markedly bicornate uteri, or where there is a double cervix or cervical opening, careful bimanual examination is sufficient for a diagnosis. When a vaginal septum is recognised it is probably best, unless the vaginæ are both well developed, to incise it, as, in case of subsequent pregnancy, it is apt to impede delivery.

(2) *Retention Accidents.*—Thirty-two cases of these have been collected with menstrual retention; eighteen were right-sided (the side more frequently less well developed), six left-sided and two bilateral. Nearly all occurred in young women, and were brought to notice by unusual and increasing pain and discomfort referred to the lower abdomen, vagina and rectum, accompanied by a slowly growing pelvic or abdominal swelling. Infection of the contents of the tumour from any cause was followed by marked depreciation of the general condition, a foetid or purulent discharge, and the usual symptoms of a septic process. Vaginal examination then revealed a more or less distinctly fluctuating tumour to one side of the vagina or in the pelvic cavity. The condition is a serious one and always demands surgical interference. There were eleven deaths in the thirty-two cases recorded; nine were due to septic peritonitis following puncture of the sac. Several autopsies disclosed the intra-abdominal rupture of a tubal blood cyst. Cases more recently treated have recovered. The indication, when as certain as possible of the condition present, is to evacuate the contents of the retention cyst through the vagina by a wide incision under strict asepsis and wash out the cavity with hot normal salt solution, to keep the patient quiet in bed, and on evidence of any peritoneal infection to open the abdomen and remove the ruptured tube that will probably be found.

(3) and (4) *Pregnancy in Double Uteri.*—Fecundity is not materially diminished in individuals with double uterus. Both sides of the uterus may be pregnant at the same time, with the fœtus in each at the same or a different period of development.



The occurrence of a double pregnancy of different periods in a uterus septus probably explains the so-called cases of superfœtation. In repeated pregnancies where both horns are equally well developed, the two uteri frequently alternate in function. Abortion is more common than in normal uteri, and is particularly frequent in uterus septus. If the pregnant horn is well developed the pregnancy will usually end as in a normal uterus; if poorly developed, there is danger of rupture during or before labour, of irregular presentation from encroachment of the other horn on the pelvic space, of abnormal insertion of the placenta, and of inefficient uterine contractions—conditions which may make the artificial delivery of the child and placenta necessary. Where there is a vaginal septum that obstructs labour it should be incised. If the pregnant horn is rudimentary in its development there is always danger of rupture; delivery *per vaginam* will be impossible, and it is always right to remove the pregnant horn, together with its ovary and tube by abdominal section as soon as the condition is definitely ascertained. Pregnancy in a rudimentary horn is most often mistaken for an extra-uterine pregnancy, but as it demands the same treatment the mistake can be pardoned. The most important differential point is the demonstration of a deep sulcus between the fundus of the uterus and the pregnant mass. About 88 per cent. of the patients die from rupture and the consequent hæmorrhage. In many of the collected cases the cervical pedicle seemed to be solid, but as in a case reported by the author, microscopic examination would probably have revealed a minute canal.

J. F. J.

#### ATHMOCAUSSIS.

FLATAU, Nürnberg (*Monats. f. Geb. u. Gyn.*, Bd. x., S. 337), from the investigation of nine extirpated uteri that had been subjected to athmocaussis and of other uteri from recent autopsies, concludes that the effects of athmocaussis are not those of steam at or above a temperature of 100° C., but of water at 75° to 85° C. The action is not sufficiently prolonged to kill bacteria, and the time it is applied is no criterion of the depth to which it penetrates. The results of athmocaussis depend less upon its duration than upon the consistence of the uterus and the size of its cavity, and the nature of the bleeding; the effect is much less when the cavity is large and the hæmorrhage copious. The best results are obtained in endometritis interstitialis, and in the so-called preclimacteric hæmorrhage, and in inoperable carcinoma of the neck of the womb (by devastation of the mucosa so as to abolish menstruation). Devastation of the entire endometrium cannot always be safely secured. Contra-indications to athmocaussis are furnished by para- or peri-metritic processes,

even of old date, and by infectious diseases of the tubes and ovaries; its use is unjustifiable in septic abortion until the uterus has been cleared out, and, in myomatous cases, requires extreme caution. Athmocaustis is no prophylactic against carcinoma, and though a supplement, is no substitute for the curette.

Elsewhere (*Centralb. f. Gyn.*, 1900, No. 3), he accuses Pincus of misrepresenting the result of the discussion at Munich, which quite upset Pincus' dogmatic position.

DÜHRSEN, Berlin (*Centralb. f. Gyn.*, 1900, No. 5); recommends the use of an intra-uterine tube of large calibre; the uterus has always to be dilated in order to ascertain the source of the bleeding. He declares vaporisation to be unjustifiable till the uterus has been proved to be empty by digital examination, and by which many a case of partial retention of the ovum, of polypi and such like, will escape improper treatment. The results of vaporisation in purely climacteric hæmorrhage continue most satisfactory.

STEINBUCHER, Graz. (*Monts. f. Geb. u. Gyn.*, B. xi., S. 546), from his experience of seventy-two cases concludes: this treatment must never be applied when there is inflammatory disease of the uterine adnexa. On the uterine mucosa it is a useful adjuvant, but no substitute for the curette. In almost half the cases the curette was employed before the steam. The method was of service in dysmenorrhœa; in endometritis with hæmorrhage or profuse discharge; in subacute and chronic uterine gonorrhœa, in subinvolution, in myomata which did not give an irregular shape to the uterine cavity; in hæmorrhage and in putrid endometritis after abortion. The results were satisfactory in septic endometritis. To obliterate the uterine cavity, steam at from 110 to 115° C. must be applied for more than two minutes. In other cases the application should be from seven to ten seconds. Success is not then so certain, but the formation of stenosis is avoided.

#### ON THE TREATMENT OF INFLAMMATORY CONDITIONS OF THE UTERUS AND ITS ADNEXA WITH DRY HEAT.

A. MANSWETOFF (*Vratsch*, 1900, No. 1) reports on the method employed in Lebedeff's clinic, one that is founded on Freund's Belastungs therapie (*Ante, B. G. J.* vol. xv., p. 468), and on Mirtl's (*B. G. J.*, vol. xv., p. 309). The special apparatus, with col-peurynter, is described with illustrations.

MIRTL (*Wiener med. Presse*, 1900, Nos. 6 and 8), claims for his thermocolpeurynter a more intense action than that afforded by any hot sitz baths or irrigations, and illustrates its beneficial effects by the histories of six cases.

“OVERLOADING” IN RETROFLEXIO UTERI GRAVIDI.

FUNKE, Strasburg (*Centralb. f. Gyn.*, 1900, No. 8) advises the use of his bag of shot or quicksilver colpeurynter not only in dealing with chronic inflammatory affections and displacements of the pelvic organs, but in the treatment of the retroflected pregnant uterus, on the basis of five cases so treated; in the last the uterus was completely reduced after only half-an-hour. The method is sure and safe and does not require any anæsthetic.

REPORT ON RECENT INTRA-UTERINE THERAPEUTICS.

By OSWALD FEIS. *Monats. f. Geb. u. Gyn.*, 1899, Bd. x., S. 65;  
*Ann. de Gyn.*, February, 1900, p. 124.

For intra-uterine cauterisation SÄNGER prefers an American silver catheter to Playfair's aluminium sound, as being, even in cases of flexion or of a narrow canal, more easily introduced up to the fundus without previous fixation of the cervix. He uses Neugebauer's speculum to expose the cervix. In persistent climacteric hæmorrhage liquid caustics, *e.g.*, chloride of zinc, are generally efficacious. It is better to wait a few days after curetting before cauterising. In endometritis two or three cauterisations, at intervals of not less than two weeks, are often sufficient.

In suppurative endocervicitis, DÖDERLEIN recommends tampons soaked in a 2 per cent. solution of nitrate of silver, or of 6 to 8 per cent. of alumnol. He injected experimentally various solutions into the uterus in six cases of hysterectomy before the operation, and in only one instance did the liquid fail to penetrate the Fallopian tubes.

v. WINCKEL deprecates energetic measures in endometritis on account of the nervous excitement which they often produce. He recommends daily douching of the uterine cavity with a 3 per cent. soda solution and later with one of  $2\frac{1}{2}$  per cent. of carbolic acid,  $\frac{1}{2}$  to 1 per cent. of lysol, or 2 per cent. of nitrate of silver, by means of a simple catheter. He disapproves of strong solutions of bichloride of mercury, or chloride of zinc or alumnol. In the metrorrhagia of fungous endometritis he uses perchloride of iron injections with Braun's syringe *without confinement to bed, but not oftener than once in two or three weeks*. He curettes as a last resource.

DUMONT-PALLIER has reported on the treatment of endometritis by chloride of zinc cones containing five grains of chloride of zinc and ten grains of rye flour. Unpleasant consequences seem to occur in 5 per cent. of the cases. During the month which follows the cauterisation it is important to catheterise the uterus to prevent atresia. Pichevin, Doléris and Charpentier condemn



this method of treatment to which various accidents, such as atrophy of the uterus, atresia, hematometra, dysmenorrhœa, necessitating hysterectomy, were attributed in a great many cases. Freund reported a case in which an injection of a 50 per cent. solution of chloride of zinc into the uterus was shortly followed by death.

OLSHAUSEN recently stated that antiseptic douches of the vagina cannot absolutely preclude infection. Exploration with the sound cannot be justified unless manual examination is impossible. No surplus of any remedial fluid should be left in the uterine cavity, any excess should be drawn back into the syringe. Uterine colic is easily produced by injections and douches, but peritonitic pain with febrile reaction caused by part of the injection gaining access to the peritoneal cavity is seldom observed. Olshausen, like Sânger, prefers the American silver catheter to Playfair's sound for intra-uterine medication. For dilatation of the cervix he recommends packing with iodoform gauze, as laminaria tents are liable to produce abrasions of the mucous membrane, which facilitate infection. The curette should not be used in catarrhal endometritis; fixation of the cervix is unnecessary except in cases of pronounced ante flexion or of a narrow os. The capital danger is perforation of the uterine wall. Olshausen advises the use of an injection, preferably one of chloride of zinc 10 or 20 per cent., after curetting.

In the discussion MARTIN spoke favourably of fixing the uterus, and also of the curette of Roux.

FALK advises the use of antrophores (*soluble bougies*) instead of Playfair's sound for applying therapeutical substances to the uterine cavity; on account of the frequent occurrence of uterine colic, he recommends rest after such applications.

LANDAU considers the curette of Roux dangerous. He dilates the cervix by means of iodoform gauze.

DÜHRSEN accepts catarrhal endometritis as indicating curettage and cauterisation combined. He applies a 50 per cent. solution of chloride of zinc with a Playfair sound.

BRÖSE never uses Braun's syringe. In the majority of cases of catarrhal endometritis, intra-uterine treatment is, he thinks, useless and even dangerous, as the introduction of instruments, &c., may carry into the cavity of the uterus infection that did not previously reach beyond the internal os.

VEIT believes that perforation of the uterus can be avoided by using the curette from above downwards and never from below upwards.

To dilate the cervix BRAUN passes a drainage tube stretched upon a sound up beyond the internal os, when it is released and the sound withdrawn. The tube is left *in situ* for twenty-four hours and then replaced by a larger one. These tubes are better



than tents, as the uterine secretion can escape freely through them. They can be used in stenosis as well as endometritis.

ROUTH advises dilatation immediately after the menstrual period, when the cervix is softer and yields more easily. If the os be very rigid, he inserts a glycerine tampon two hours before dilating. The glandular secretion produced by the tampon softens the cervix.

STURLINGEN recommends the use of an instrument constructed on the principle of a glove dilator.

SÄNGER does not believe that digital exploration of the uterus can ever be supplanted by curettage and endoscopy. Moreover dilatation should be slow, whenever, as in a great number of cases, it is impossible to obtain it without using force. The best tent is the laminaria. In uterine hæmorrhage from obscure sources about which the examination of the mucosa gives no information, digital exploration becomes particularly necessary. In almost every case it should be followed by scraping the uterine mucosa and a microscopical examination. In retention of placental *débris* after abortion the cervix should be sufficiently dilated to permit accurate digital exploration, but there should be no curettage without such exploration. After complete dilatation of the uterus, packing is unnecessary. When placental *débris* are in a state of putrefaction, tents should not be used. Digital exploration is also called for in early abortion, in myoma of the body of the uterus, in submucous myoma or in affections of the endometrium suggestive of malignancy. The tents are left one minute in a 5 per cent. boiling solution of carbolic acid, and then kept in a saturated solution of iodoform in ether; immediately before use they should be placed for half a minute in a 1 per cent. boiling solution of soda. The uterus should be washed out before and after the digital exploration. Anæsthesia can often be dispensed with. If the temperature rise or the pulse become accelerated during the treatment, the tent should be removed. In ante flexion the tent can be introduced by placing the patient in Sim's position. In virgins he seldom dilates with the laminaria tent, but performs at one sitting under anæsthesia all the necessary manœuvres.

FALK describes the introduction of a tent as follows: the uterus is first catheterised, the patient is placed in the genu-pectoral position, the anterior lip of the cervix is fixed and the tent inserted after placing it in boiling water, bending it suitably, and finally soaking it in a 1 per 1,000 solution of bichloride of mercury. Twenty-four hours after removing the tent metallic dilators are introduced and another tent is inserted.

APPERT treats chronic gonorrhœal metritis by repeated applications of gauze soaked in glycerine of creosote or of camphorated naphthal.

LUTAUD treats endometritis as follows: after dilatation by laminaria tents, washing out of the uterus with a 3 per cent. solution of soda, application of a solution of iodoform in ether to the cavity, followed by application of sponges charged with naphthol, iodoform, iodine tincture, salicylic acid, or glycerine of creosote, which are left in position for six hours and changed every two or three days. The curette is only used in cases of hæmorrhagic endometritis.

FEHLING considers laminaria tents to be the best means of dilating the cervix, and thinks the results obtained by packing the cervix with gauze very inferior. He prefers Playfair's sound to the American caustic holder, which catches too easily in the ridges of the *arbor vitæ*. Before cauterisation and abrasion he dispenses with irrigation, and cleans the cervix with a sound covered with wool, first dry and then soaked in some antiseptic solution. After abrasion, he applies caustic twice at four days' interval.

P. Z. HEBERT.

#### A METREURYNTER.

PREISS, Kattowitz (*Centralb. f. Gyn.*, 1900, No. 10) describes an intrauterine balloon consisting of a stem, like a brown English catheter, which is connected by means of a tube with an india-rubber ball syringe. The balloon is easily introduced empty, and distended after it is in the uterus. In Zweifel's Hystereurynter the same arrangement is connected with a metallic stem, which would be more easily kept aseptic than a tube of cotton material impregnated with gum.

#### KRAUROSIS VULVÆ.

BALDY AND WILLIAMS (*A. J. M. S.*, 1899, November) see no reason to admit trophic disturbance to be the explanation of the obscure etiology of Kraurosis vulvæ, but believe the cause to be constitutional, or more probably of a purely local nature, as is suggested by the pruritus so constantly associated with its commencement. A case described was perfectly cured by operation.

This rare and distressing affection is more fully noticed by Phillips in *The Practitioner*, April, 1900, p. 435.

#### TYPHOID ULCERATION OF VULVA AND VAGINA.

A. J. LARTIGAN (*Boston Med. Surg. J.*, 1899, September 7) records a unique case of ulceration of the vulva and vagina of a young woman, in the course of enteric fever. B. to. abd. was found in the ulcers.

## PERIVAGINITIS PHLEGMOSA DISSECANS.

v. LINGIN (*Archiv. f. Gyn.*, Bd. lix. S. 595) collects seventeen cases of the above singular disease which is characterised by the casting off of the portio vaginalis with the whole or part of the vaginal wall; three were fatal. The chief cause was in many cases acute infectious disease, especially typhus, in two instances local application of perchloride of iron; in some the etiology was quite obscure. He reports a recent observation of his own occurring after a fever in a woman of 39. The remarkable fact that the necrotic mass always consists of vaginal wall and portio vaginalis suggests to v. Lingin that the cause of this disease must in many cases consist in the occlusion, embolic or thrombotic, of a certain area of circulation, and the necrosis of tissue so starved.

## COLPOHYPERPLASIA CYSTICA.

LINDENTHAL, Vienna (*Zeits. f. Geb. u. Gyn.*, Bd. xl., S. 375) reports the result of an exact bacteriological and histological investigation of a case of colpohyperplasia cystica or emphysema vaginæ in a girl of 18 who died of pulmonary tuberculosis. He found histological cyst formation in the vaginal wall with necrosis and cellular infiltration around the cysts. These changes were evidently due to the vital action of anaerobic B. œdematis which were proved microscopically and by cultures to be present in the tissues, and which not only formed gas in test tube and animal tissues, but by which also a morbid process analogous to the emphysema vaginæ was induced in the vagina of some guinea pigs.

## ACCIDENTAL INJURIES SUB COITU.

O. SCHAEFFER Heidelberg (*Centralb. f. Gyn.* 1900, No. viii.), met with a laceration of the vaginal vault in an hysterical primipara who had vaginismus and pruritus. The tear, 2.5 cm. deep and 4 cm. long, was under the base of the right broad ligament. The bleeding was arrested and the wound stitched up; during this operation there was a sudden outbreak of general urticaria. In regard to other similar injuries *sub coitu*, Schaeffer mentions the cicatricial bands in the upper part of the vagina which are found more especially in anæmic and decrepid women, often quite by accident; he quotes five cases. He also discusses the detachment of the posterior edge of the hymen, injuries of the recto-vaginal septum and those of the parts about the anterior commissure, especially of the nymphæ which are connected with an abnormally resistant hymen. These injuries are all of forensic importance.



WICHMANN (*Aerztliche Sach. Zeit.*, 1900, No. 4) records a fatal case in a woman in the ninth month of pregnancy. A laceration 1.5 cm. deep and 2 cm. long to the right and below the clitoris had torn into the meatus of the urethra and the right corpus carnosum of the clitoris.

SKROBANCKI (*Vratch*, 1899, December 4), reports a 2 cm. laceration of the perineum of a healthy 22 year old peasant woman, on her wedding night. The anus was not involved. Twenty-two similar cases have been recorded.

#### PROLAPSE OF THE URETHRA.

MEYER, Berlin (*Archiv f. Gyn.*, Bd. lix., S. 618), considers labour a most important factor in producing urethral prolapse in women. Repeated deliveries certainly induce relaxation of the urethral attachments and more or less protrusion of the mucous membrane out of the meatus. The redundant ring of tissue should be cauterised or amputated and the cut edges closed by catgut suture. In a recent case occurring four weeks after childbirth, rest in bed and the application of an ice bladder relieved all difficulty in making water in three days, and the woman was well enough to be discharged in a week and had no prolapse some months later. Amputation of a necrotic prolapse was successfully performed in Engström's way, by Abel, in the case of a maid, aged 12. Urine was passed spontaneously from the third day, and she was discharged on the ninth. The prolapse had supervened during her treatment for left lateral scoliosis by suspension.

#### PERSISTENCE OF GARTNER'S DUCT.

VASSMER, Hanover (*Archiv f. Gyn.*, B. lx., S. 1), in a woman who died fourteen days after delivery, found the right Gartner's duct in the muscular tissue of the uterus; the left one was traced from the parametrium on to the upper part of the portio, and then after an interruption in the lateral wall of the vagina, along the vaginal vault to the lower third of the vagina, where it terminated without any opening. The vaginal portion of the duct had undergone cystic dilatation, and was lined with one or two layers of epithelial cells, with islands of typical squamous epithelium.

#### COCYGYDYNIA.

ROSE (*Centralb. f. Gyn.*, 1899, No. 47), in two very obstinate cases of coccygodynia, succeeded in entirely removing the pain by the application of rectal massage. In both cases there was much oedematous swelling about the sacral apertures, which he set down to obstruction and congestion in connection with other



pelvic disease, and which caused the pain by pressing upon the nerves.

FRED EDGE.

#### SPONDYLOLISTHESIS.

V. BRAUN-FERNWALD, Vienna (*Archiv. f. Gyn.*, Bd. lix. S. 662) has met with a case of spondylolisthesis in a woman who has borne five children spontaneously. In discussing the diagnosis the author differs from accepted opinion in saying that (1) no increased inclination of the pelvis is to be expected in the first stage of the disease; (2) the "rope-dancer's walk" with short steps and crossed feet, does not depend on the form and inclination of the pelvis, but rather upon whether the morbid process is still going on and the woman has pain when she steps out freely.

#### PYOSALPINX REMOVED IN EARLY PUERPERIUM.

R. MILNE MURRAY (*Edinburgh Med. Journ.*, 1900, February) called to an obstetric case on July 12, 1899, learned that the patient had been awakened on the 7th by excruciating pain in the left side, relieved by poultices and laudanum; that there had since been present a dull aching pain, with occasional exacerbations, while the temperature had ranged from  $100^{\circ}$  to  $101.5^{\circ}$ ; and that on the 9th labour pains had set in, but had ceased entirely when the os reached the size of a half-crown piece. He found the vagina moist, the os admitting two fingers, temperature  $101.5^{\circ}$ , pulse 98, rather compressible. The history of the attack, together with the previous history of the case, lead Milne Murray to suspect the escape of pus into the peritoneal cavity. He considered the advisability of immediate operation, but decided to wait till delivery occurred. On the 14th a child was safely born. On the 15th he removed the left ovary and tube, and irrigated with lysol solution, leaving one pint in the abdomen. The patient was in a very precarious condition at the time of operation, but made an uninterrupted recovery. The removed tube was much dilated, and upon stripping it a minute drop of yellow purulent material escaped at the uterine end.

H. M. J.

#### PYOSALPINX.

J. K. KELLY (*Glasgow Med. Jour.*, 1900, February) describes three cases of double pyosalpinx, in one of which the sudden onset of severe illness was suggestive of tubal rupture.

H. M. J.

#### REMOVAL OF BOTH UTERINE APPENDAGES DURING PREGNANCY.

By J. WESLEY BOVÉE. *Amer. Jour. of Obst.*, 1900, February.

This paper, in addition to cases reported, contains a table of 38 removals of both appendages during pregnancy, collected

from various sources; 23 of these were done for some kind of ovarian cyst, 1 for "tumours of both ovaries," 6 for pus tubes, 3 for chronic salpingo-oophoritis, 1 for a large uterine fibroid, 1 for hystero-epilepsy, and in 2 cases the reason for the operation was not given. Only one death occurred in the 38 cases, and in this case the patient was a half-starved woman who had been severely beaten by her husband just before the operation. Operations can therefore be done during pregnancy with nearly the same impunity as when this complication does not exist. Special attention is drawn to the risks of pyosalpinx as a complication of pregnancy. During the stretching of the broad ligaments incident to the enlargement of the pregnant uterus, a pyosalpinx is disturbed in its anatomical relations and may at any time leak into the peritoneum. During the contractions of the uterus at parturition it may rupture. A case of double pyosalpinx complicating pregnancy is reported, the pregnancy was in the third month, the pus tubes were removed by abdominal section, the patient went on to full term. Of the 38 cases in the table 28 were delivered at or near full term. In operating during pregnancy it is important to molest the uterus as little as possible. No forceps or volsella should be applied to it. The tube and ovary should not be removed too close to the uterus. With the first evidence of uterine pain or contraction opium should be administered sufficiently freely to control any efforts at abortion.

J. F. J.

#### APPENDICITIS—ITS SIGNIFICANCE TO THE OBSTETRICIAN AND GYNÆCOLOGIST.

FALK, Hamburg (*Centralb. f. Gyn.*, 1900, No. 7), reports the case of a 34 year old VII-para in whom an epitaphlitic abscess developed in the sixth month of pregnancy, which was incised and drained after excision of the necrosed appendix. She recovered, and had a normal labour at term. Commenting on the difficulty of diagnosis, he mentions two other personal observations, (1) in a woman in the fifth month, an epitaphlitic abscess was diagnosed, which proved, on operation, to be a cystic ovary with a twisted pedicle; (2) in another case a suspected ectopic pregnancy proved to be a pyosalpinx with an inflamed appendix.

PINARD (*Acad. de Medicine*, 1900, March 6), has met with several cases of appendicitis in pregnant women. There was always early and persistent pain, muscular rigidity of the abdominal wall, especially of the right side, vomiting, and high fever. As peritonitis, except after rupture of the uterus, is unknown in pregnancy, the diagnosis is easy. It should be made as soon as possible, and intervention must not be delayed.

Pinard's results were satisfactory, even when patients were almost *in extremis*, and pregnancy was not interrupted by the operation.

#### PERITONITIS.

T. B. GRIMSDALE illustrated a paper read before the Birkenhead Medical Society on June 12, 1900, by the following cases: (1) solid ovarian tumour with twisted pedicle; (2) localised collection of pus containing pure culture of staphylococci; (3) tuberculous pyosalpinx with tuberculous peritonitis; (4) large localised peritoneal blood cyst; (5) ruptured ovarian cyst with four months' pregnancy; (6) ruptured tubal pregnancy of tenth week; (7) sub-peritoneal fibroid in an old woman of 67.

#### PARAMETRITIC ABSCESS.

ALBAN DORAN (*West Lond. Med. Journ.*, 1900, January), reports a case in which the pus from a parametritic abscess travelled backwards through the lesser sacro-sciatic foramen, then outwards, following the track of the obturator internus tendon, and finally forwards, passing on the inner side of the femur to point about two inches below Poupart's ligament, on the front of the thigh.

H. M. J.

#### PRIMITIVE TUBERCULOSIS OF THE GENITAL TRACT.

By J. M. POPOV, Thesis of St. Petersburg, 1898.

*Annales de Gynéc.*, Paris, 1900, February.

Primitive tuberculosis of the genital tract is very rare, and the clinical evidence does not solve the question as to how the tubercle bacillus penetrates the organism. The author has endeavoured to ascertain how a disease so strictly localised can be produced, and in two series of experiments has injected a bacillary culture into the vagina of guinea-pigs. In one the inoculation was made in the walls of the healthy vagina; in the other, inflammation was previously provoked by some irritating substance or a needle.

In both these series well-marked tuberculous granulations were produced locally, for a month or more, and the neighbouring lymphatic ganglia became inflamed; but the morbid process in no case extended to the internal organs.

The question as to whether the infection always remains localised or can become generalised still remains open. The author considers that the puerperal state and the menstrual period are the most favourable conditions to the reception of the local infection, and points out that after labour the general infection often receives a great impulse in its development.

P. Z. HEBERT.

## ON TUBERCULOSIS OF THE FEMALE GENITAL ORGANS.

VOIGT (Göttingen), *Archiv f. Gyn.*, Bd. lix., S. 609.

A clinical and anatomical description of 5 cases. The bacillus was demonstrated in 2, and in 1 the tissue of the vagina, cervix, and body of the uterus contained large numbers of bacilli with embolic plugs containing bacilli in many places.

## PUERPERAL SEPTICÆMIA CAUSED BY TUBERCLE BACILLI.

DOLÉRIS reported at a recent meeting of the Paris Medical Society two cases of septicæmia occurring in tuberculous subjects, in both of which characteristic cultures of tubercle bacilli were obtained from the blood. Doléris believed that owing to the traumas associated with the delivery the bacilli were enabled to enter the general circulation. So-called tuberculous septicæmia is very intense in character and rapidly fatal.

HENRY JELLET.

## ON CHORIOEPITHELIOMA AND ITS ANATOMICAL AND CLINICAL RELATIONS TO VESICULAR MOLE. By PIETRO MARCHESI.

*Annali di Ostetricia e Ginecologia*, 1900, February.

Among the various views expressed by different investigators as to the origin of the epithelium of the chorionic villi, Waldeyer gives the following: (1) The epithelium of the villi is simple and foetal in origin. (2) It is simple and maternal, that is, derived from the uterine epithelium. (3) It is simple, maternal, of connective tissue origin, formed from the decidual cells. (4) It is double, of foetal origin, with an internal connective tissue layer and an external epithelial layer. (5) It is double, the internal layer is foetal epithelium, in which is extended the endothelium of the dilated maternal placental vessels. (6) It is double, the internal layer connective tissue of maternal origin, the external is maternal vessel endothelium as in 5. (7) It is double, the internal layer is foetal epithelium, the external is derived from the maternal epithelium of the uterine glands, into which the villi penetrate. (8) It is double, both layers are foetal and ectodermic (epithelial), the external stratum is a syncytium, the external layer also has cilia. (9) It is triple, there is a double foetal layer in which lies a maternal layer. (10) It is triple, all the layers are of decidual maternal origin. It is evident that we have here all the elements for a pretty quarrel as to the origin of any growth which may arise from the chorion or its vicinity. There are ten views as to the origin of the chorionic epithelium, and these, with variations, may lead to a still larger number of opinions as to that of deciduoma malignum, so called.

The subject dealt with by Marchesi is rather the relationship



and diagnosis between benign (hydatid mole) and malignant (deciduoma malignum) growths arising from the chorionic villi; he sums up as follows:—(1) There exists no characteristic difference in any part of the villus between benign and malignant moles. (2) The most marked difference is given from the clinical course which corresponds to the anatomical fact of an atypical proliferation and relative invasion by the epithelial elements of the villi and also by the connective tissue (*vescicole*) which finally reach the uterine muscular tissue; these villi may have the same structure as those of a benign mole. (3) This formative activity of these elements (and especially of the epithelial) has no special energy, the destructive process of the mole may still be arrested; when this is unchecked we have the chorio-epithelioma. As Resinelli has already stated, it is impossible to make two distinct groups of destructive moles and decidual tumours.

The spontaneous cure of chorio-epithelial proliferations is, Marchesi believes, possible; nevertheless, a growth of the chorionic epithelium, or of this and its stroma, penetrating the uterine tissues and capable of being carried to a distance and reproducing the same growth, must be looked upon as malignant from the first and treated as such.

FRED EDGE.

#### THE EPITHELIAL GERMS OF ADENOMYOMA OF THE UTERUS AND THEIR DIFFERENTIAL DIAGNOSIS.

PICK, Berlin (*Archiv. f. Gyn.*, Bd. lx., S. 174), found in the outermost muscular layers of the back of the corpus uteri a small number of isolated dispersed epithelial formations surrounded by typical lymph-adenoid stroma. He says that such a casing of cytogenous connective tissue round isolated dispersed glandular or cystic epithelial growths in the uterine wall typifies these growths indubitably as derivatives of Müller's ducts—not of Wolf's ducts, the canals of the Wolffian body or descendants of the germ—or peritoneal epithelium. There are plenty of cases of indifferent origin, since on the one hand cytogenous connective tissue round Müller's ducts is not invariably present; on the other hand the inclination in Wolffian epithelium to produce a stroma of cytogenous tissue increases *pari passu* with the activity of glandular increase.

#### CANCER.

SHATTOCK reported to the Pathological Society of London, January 16, 1900, an instance of "Spontaneous" Carcinoma of the Uterus in a Rabbit, as bearing on Lack's experiment. The possibility asserted by Lack, and supported by animal experiment, of artificially producing cancer by rubbing normal epithelium into lymph spaces, and also the opinion of McFadyean

that cancer is unknown in guinea-pigs (? rabbits), is upset by this observation.

BALLANCE concurred that Lack's case was merely coincidence.

KÖNIG (*Beiträge z. Geb. u. Gyn.*, Bd. ii., Heft 3) reports on the results of the radical abdominal operation for uterine carcinoma in the Berne Clinic. The enlarged Freund operation, *i.e.*, abdominal total extirpation with clearing out the pelvis, was performed seven times; three patients succumbed, four were cured. But of course these cases were ones not very hopeful, and some unfavourable. The future must teach us whether the addition of such serious interference as that of clearing out the pelvis is an improvement to abdominal hysterectomy. Theoretically the operation is justified. Practically the question still is the selection of the cases for which the operation is suitable.

#### TOTAL EXTIRPATION OF VAGINA WITH THE UTERUS FOR CARCINOMA.

SIPPEL, Frankfurt (*Centralb. f. Gyn.*, 1900, No. 4) describes a case of vaginal carcinoma in a woman of 64, in which he opened the ischio-rectal cavity by lateral incision between the anus and the tuber ischii, and removed the vagina and uterus unopened in their normal connection. The woman made a good recovery. As advantages of this method he mentions the good view and accessibility of the field of operation, the possibility of avoiding any contact whatever with the carcinoma or contents of the vagina. Sippel advocates the removal of the uterus in all such cases; the amount of the vagina removed depending on the circumstances of each case. He recommends the same incision in operating upon congenital or acquired vaginal atresia.

#### PYOMETRA—AFTER CAUTERY.

HOFMEIER brought before the Berlin Obstetrical and Gynæcological Society (January 12, 1900) a pyometra as large as a child's head, which had ensued on the cauterisation of an inoperable carcinoma (two months previously).

#### OÖPHORECTOMY IN THE TREATMENT OF CANCER.

By W. ROGER WILLIAMS. *Med. Times*, 1900, March 3.

Oöphorectomy is seldom followed by mammary atrophy, and when Schwinzinger put forward in 1889 the idea that castration might prevent the development of cancer in the predisposed, and its recurrence after operation, he did not support it by any clinical evidence. In 1896, Beatson reported favourably of two out of three cases of inoperable cancer treated by castration; one died soon after operation with hepatic metastasis, and the disease soon reappeared in one supposed to be cured. The

most favourable statistics by Stanley Boyd do not record any diminution of the disease worth mentioning in more than four out of fifteen cases, and the improvement was but a temporary one in them. There has been no difficulty in justifying numbers of new specifics (chian turpentine, cinnamon, &c.) for cancer by alleged cures far more convincing than any advanced for castration.

The clinical history of the disease in this part of the body is full of fallacies for the unwary. In some 26·5 per cent. it runs a very chronic course, in more than a third of these lasts over ten years, sometimes over twenty or even thirty years. In such chronic cases recurrence may be delayed for from three to ten years, or exceptionally even longer, and one may occasionally meet with spontaneous retardation, arrest, or even retrogression. Local retrogression may coincide with the outbreak of the disease elsewhere, with the advance of pulmonary tuberculosis, exhausting suppuration or other enfeebling diseases. Thyroid medication and seropathy have had similar results, and the progress of cancer may be checked by syphilitic cachexia privation or malnutrition. *Moreover marked amelioration has been observed after simple exploratory laparotomy.* Errors of diagnosis are fertile of fallacy as regards the cure of cancer. Chronic mastitis (especially the *induratio benigna antiquorum*), tubercle, syphilis, abscess, cystic disease, galactoceles, furnish specimens illustrating the mistakes of surgeons not without experience; actinomycosis, mycosis fungoides, &c., are taken for malignant disease more often than is supposed, and certain forms of cancer are simulated by keloid, lupus keloid and scleroderma.

Castration probably tends to favour rather than prevent the development of mammary cancer, a disease to which women are more liable when the ovaries have commenced to dwindle in size as well as function, and one affecting the obsolete rather than the active gland. The average age of its onset is 48, that of the menopause in English women 45. An analysis of the causes of death of all Spenser Wells' patients who recovered from complete ovariectomy confirms the idea that extirpation of the ovaries increases the liability to cancer. A considerable number of cases are now recorded in which cancer has supervened after the removal of both ovaries for various morbid conditions. Castration for cancer, is I believe, worse than useless.

#### OVARIOTOMY PER ANUM.

PETERS (*Wiener kl. Wehns.*, 1900, v.), reports the following case:—A woman had had extensive prolapse of the rectum for twenty years. Her internal genitals were normal save that there was a cystic tumour of the left ovary as large as a fist.



After the rectum had been dissected from the surrounding tissue, a broad incision was made into Douglas' pouch, the rectum was drawn downwards and backwards and ligatured provisionally. The cyst was then drawn down and extirpated, the pedicle returned and Douglas' pouch closed by joining its anterior fold to the serous covering of the upper part of the rectum. The rectum was then resected. Apart from a protracted faecal incontinence the patient made a good recovery.

WALLS, at the North of England Obstetrical and Gynæcological Society, January 19, 1900, showed a specimen with microscopic section of an ovarian dermoid delivered through the anus; it had been apparently forced downwards by the advance of the foetal head in labour till the rectum tore longitudinally; the woman made an excellent recovery.

#### PAPILLARY CYSTOMATA OF THE OVARY.

UFFENHEIMER, Berlin (*Münchener med. Wehns.*, 1899, No. 21, 22), has investigated the histology of papillary cystomata by microscopical examination of the specimens collected at the Berlin University, Frauenklinik, and concludes that they arise from germinal not from follicle epithelium. Ciliated epithelium comes from metaplastic psammoma by the degeneration of epithelial forms. Proliferation at first extends in depth. Papillæ may grow outwards spontaneously or break outwards by pressure.

#### FOLLICULOMA MALIGNUM OVARII.

GOTTSCHALK, Berlin (*Archiv. f. Gyn.*, Bd. lix., S. 676), under the above name describes a new malignant tumour of the ovary with the following characteristics: (1) the formation of innumerable spherical plasmodial nucleated bodies within which in the first place there is a splitting of the nucleus by continued fission, (2) when this has gone on to a certain extent liquefaction begins in the centre and proceeds till there is merely a cyst walled by a single layer of cubical plasmodial cells. In the case under observation, a woman of 48, about eight litres of ascitic fluid was drawn off and a tumour the size of the fist was removed by laparotomy in March, 1898; the patient is still well.

#### OVARIAN TUMOURS.

G. T. BEATSON (*Glasgow Med. Jour.*, 1900, February), removed from a woman, aged 67, an ovarian cyst with a mass at one end of it like a fibrous tumour, but microscopically, by its highly cellular stroma of fibrous tissue enclosing groups of epithelial cells, appearing to be a true carcinoma.

In another patient, aged 35, a tumour, supposed to be an ectopic pregnancy or an ovarian cyst, disappeared just before



the date of intended operation, and Beatson could only suppose that he had mistaken a distended bladder for a cyst. Four months later he removed a multilocular cyst. The peritoneum contained an oily fluid.

H. M. J.

JASON WOOD (*Bradford Med. Chir. Soc.*, 1900, February 20), read notes of a case of a married woman of 48, from whom he removed a multilocular ovarian cyst universally adherent and without any trace of a pedicle; some of the loculi contained foetid green pus, some of which escaped into the peritoneal cavity. The small intestines were confined to the upper part of the abdomen, so that the cavity the tumour had occupied remained. It was washed out and packed with gauze. The ovaries could not be recognised on account of the inflammatory thickening of the peritoneum. Jason Wood suggests that the ovary became detached from its usual connections and then underwent cystic degeneration.

#### OVARIAN DERMOID CYST WITH TORSION OF THE PEDICLE.

F. J. McCANN (*West Lond. Med. Jour.*, 1900, January), removed a right ovarian dermoid cyst with twisted pedicle from a patient, aged 24, cognisant only of increase in her abdomen till suddenly attacked with pain and sickness, symptoms attributed by McCann to the torsion found. On the left side was an ordinary multilocular ovarian cyst of smaller size.

H. M. J.

A. SMITH (R.I.A. of Medicine, 1900, January 5,) exhibiting a multilocular cyst of the ovary, alluded to the sudden severe pain which had been caused by torsion of the pedicle.

#### TORSION ON THE PEDICLE OF AN OVARIAN CYST.

F. A. SOUTHAM (*Med. Chron.*, 1900, January), provisionally diagnosed (Thomas Harris concurring) recurrent appendicitis in a woman aged 63. When anæsthetised for operation, a smooth, round, very mobile tumour the size of a cocoa-nut became evident in the right iliac fossa. This proved to be an unilocular ovarian cyst with a twisted pedicle three inches long. All signs or results of appendicitis and peritonitis being absent, the attacks were attributed to occasional increase in the torsion of the pedicle.

H. M. J.

#### DERMOID CYST WITH TWISTED PEDICLES IN A CHILD OF 10.

MEIGS (*Boston Med. Surg. J.*, 1899, September 28), successfully removed from a child of 10 a cyst containing sebaceous matter, cartilage and bone, the pedicle of which was twisted a

turn and a half. It had caused urinary symptoms and a suspicion of hydronephrosis.

#### ACUTE TWISTING OF THE PEDICLE IN CASES OF UNSUSPECTED OVARIAN CYST.

CULLINGWORTH (*Practitioner*, April, 1900) in a clinical lecture, illustrated by five cases of remarkable interest, quotes Bland Sutton's statement that "the predominant signs of acute axial rotation of abdominal tumours . . . are those common to a strangulated hernia *minus* stercoraceous vomiting," and says that when the existence of a tumour has not previously been suspected the symptoms so closely simulate those of acute intestinal obstruction that the most careful investigation is necessary to avoid error. The difficulty is increased during pregnancy and parturition, when the enlarged uterus may mask the existence of a second tumour, and is hardly less during or soon after delivery, when enlargement and tenderness may be ascribed to the uterus itself or to puerperal peritonitis. And experience has shown acute axial rotation to be particularly liable to occur during pregnancy and parturition. When the rotation occurs slowly the tumour becomes slowly inflamed and acquires adhesions, but the immediate effect of acute twisting is to obstruct the circulation through the pedicle, to cause intense venous congestion in the tumour, rupture of vessels and hæmorrhage into the cyst and into the cyst walls. The tumour suddenly enlarges and becomes tender; there is pain, vomiting and collapse. The lividity of the tumour is hardly distinguishable from gangrene, but on washing and draining from the blood the dark colour disappears. The hæmorrhage may be fatal or the patient may die from peritonitis, intestinal paralysis, septicæmia, or from the exhaustion of prolonged suppuration. Operation, our only hope, should, as soon as the diagnosis has been established, be performed with as little delay as possible. In the first case narrated, that of a single woman of 22, there were three separate attacks of severe abdominal pain, doubtless due to distinct stages of twisting. The first acute symptoms almost always subside and the pedicle may right itself; otherwise it is hard to explain a history of such an attack with evidence, on operation, of hæmorrhage into the cyst but none of a twisted pedicle. In the majority of cases further rotation takes place with recurrence of the acute symptoms. The second case, about five months pregnant, did not abort, though the twist so involved the broad ligament as to drag up the adjacent peritoneum and the cæcum at its outer border. The third was an example of axial rotation of the cyst itself near its centre, and of a pelvic hæmatocele unconnected with ectopic pregnancy. The fourth case, when operated on four days after parturition, showed a

pedicle with three complete turns. The first attack in the fifth case had been fourteen months earlier, and there had been no definite recurrence till some three weeks before operation. There was a cystic adenoma of the right ovary, the pedicle twisted three-fourths of a turn. Both the latter cases ended unfavourably, but should be studied in the original.

OVARIAN CYSTOMA COMPLICATING PREGNANCY.

By W. S. STONE. *Amer. Jour. of Obst.*, 1900, January.

A primipara in good general health was examined in the thirtieth week of pregnancy, when a tumour of regular and smooth outline, that appeared to be of solid consistence, was felt behind the cervix. This tumour almost filled the pelvic inlet, and all attempts to push it up above the brim were futile. An exploratory posterior vaginal cœliotomy proved the tumour to be an ovarian cyst. It was tapped and removed *per vaginam*. The patient did well after the operation, but in spite of large doses of morphine uterine contractions began on the third day and slowly increased. Dilatation was completed manually under chloroform and a small premature child delivered alive by the breech. With the aid of an incubator and careful feeding the child lived. The mother made a good recovery.

J. F. J.

A MULTILOCULAR PSEUDOMUCINOUS CYST-ADENOMA OF THE RIGHT OVARY WITH PRONOUNCED SYMPTOMS OF DIABETES; OPERATION, WITH RECOVERY, FOLLOWED BY THE DISAPPEARANCE OF THE SUGAR FROM THE URINE AND THE DIABETIC SYMPTOMS. By HENRY D. BEYEA.

*Amer. Journ. of Obst.*, 1900, February.

The object of this paper is to call attention to a seeming etiological relationship between certain diseases of the female internal genital organs and some cases of diabetes. The patient, aged 53, had always had good health. The menopause took place at 49 years of age, but after two and a-half years of amenorrhœa she was seized with pain in the lower abdomen, followed by profuse bleeding from the uterus for a week. Ever since the flow has occurred every two weeks, gradually getting worse. Ten months before coming under observation she discovered a tumour growing in the lower abdomen. Her general health deteriorated, and she began to complain of great thirst, having to drink large quantities of water. Symptoms of languor, weakness, sleeplessness, thirst and frequent micturition grew worse, while her appetite became enormous. The tumour grew rapidly, and for a month before examination had com-



pletely filled the abdomen. On her admission to the hospital there were all the signs of a large ovarian tumour and some œdema of the lower limbs; the skin was dry and rough. The specific gravity of the urine was 1042, no albumin, but a large amount of sugar was present. The multilocular pseudomucinous cyst was removed on July 21, 1897. During the first eighteen hours after the operation the thirst was severe, but afterwards seemed to be less than before operation. On a diabetic diet the amount of sugar in the urine diminished from day to day, and at the end of three months had almost disappeared. She went home, followed her ordinary occupations and took ordinary diet. Six months later there was no sugar at all in the urine. The author then refers to the case described by Halliday Croom in the *BRITISH GYNÆCOLOGICAL JOURNAL* for February, 1896, in which two large colloid ovarian cysts were removed from a patient, aged 53, with glycosuria. There were no symptoms of diabetes, and the sugar disappeared from the urine within three months of the operation. Neither in this nor in the case reported by Beyea was there any hereditary history of diabetes, and the patients had been healthy before the described illness. In both instances the cystoma was a pseudomucinous cyst-adenoma, unilateral and weighing 22 lbs. in the author's case, bilateral and weighing 56½ lbs. in Croom's case. The author says: "There is at least strong evidence that the presence and growth of the multilocular pseudomucinous cyst-adenomata stood in the relationship of cause and effect, and were not merely coincident." In what way does the cause operate? In discussing this question it is pointed out that Hammarsten determined that the material contained in the loculi of these cystomata was mostly, and sometimes wholly, composed of a peculiar mucoid substance secreted by the cylindrical epithelial cells lining the loculi. It was not mucin, it remained unchanged on being treated with acetic acid. Hammarsten called it "pseudomucin." He found that by boiling pseudomucin with a dilute solution of mineral acid a sugar was separated, which in turn was strongly reduced by an alkaline solution of the sulphate of copper. Three other forms of "pseudomucin" have been described as present in these cysts. They may be called glycoproteids. The question is asked, "Was not this glycoproteid in some way set free in these particular instances and excreted by the kidneys as sugar?" "May there not exist a form of this cystoma, the walls and physical and chemical properties of the contents of which may allow absorption through channels to the kidneys producing sugar in the urine and the symptoms of diabetes?" The method of absorption is difficult to understand, but most probably would be through the vascular system. Croom's



explanation of the cause, viz., the mechanical interference with the glycolytic function of the pancreas or with the hepatic circulation is inapplicable in this case as the tumour, in the author's opinion, was not large enough to affect the pancreas or the hepatic circulation. The solution of the problem is not rendered easier by Imlach's case, in which a large quantity of sugar in the urine and symptoms of diabetes were associated with a pyosalpinx. Disappearance of the glycosuria and complete recovery followed removal of the pyosalpinx. This case does not lend support to the view that absorption of pseudomucin is in any way the cause of the glycosuria.

The author concludes "That in rare instances where disease of the female internal genital organs is associated with diabetic symptoms, and a large quantity of sugar is found in the urine, the diabetic symptoms and the glycosuria seem to be dependent on the disease of the genital organs."

J. F. J.

#### THE ORIGIN OF DERMOID CYSTS.

By BANDLER (Berlin). *Archiv. f. Gyn.*, Bd. lx., S. 377.

In the author's opinion dermoids do not arise by parthogenesis, *i.e.*, the development of an ovum in the patient, but from the growth of some included or misplaced cells which develop as they would have done in their proper positions; most dermoids appear accordingly after puberty between the ages of 20 and 30 years. Like any other growths they may become malignant. The argument against parthogenetic origin of dermoids, whether cystic or solid (teratomata), is based on the following reasons: (1) the absence of any analogy in the higher animals of the development of an unfructified ovum to foetal structures; (2) all dermoids do not contain portions of all three germinal layers; (3) the parthogenetic theory does not hold for dermoids of the pelvic connective tissue, and of other parts of the body containing portions of all the germinal layers; (4) foetal structures can hardly develop without a placenta; (5) or the rudiments of a foetus to secondary teeth and long hair; (6) the presence of individual portions without general development; (7) such portions always belonging to one half of the body; (8) the not infrequent occurrence of dermoids on both sides of the body; (9) the supposition of a third ovary for those cases in which both ovaries are found intact; (10) multiple dermoids of the same ovary; (11) dermoids of the testicle; (12) the frequent association of dermoids with cystadenoma; (13) the fact that the skin of the so-called embryo is part of the cyst wall; (14) the so-called foetus never forms a lithopædion; (15) the capacity of growth at the time of puberty.

FRED. EDGE.

• DERMOID CYSTS OF THE PELVIC CONNECTIVE TISSUE.

SKUTSCH, Jena (*Zeits. f. Geb. u. Gyn.*, Bd. xl., S. 353), gives the details of two primary dermoids of the connective tissue of the small pelvis, such as described by Säger and de Quervain, and a tabular statement of the nineteen cases already published. The size of the cysts varied from that of a pigeon's egg to tumours that reached nearly to the navel. Most were simple dermoids, some contained hair and bones; only the so-called dermoids of the rectum exhibited a complicated teratoid structure. These tumours have no connection with ovarian dermoids. The symptoms they cause are slowly developed, ultimately they may be such a hindrance to delivery as to necessitate craniotomy. They are never freely moveable, and in their diagnosis the relation of the tumour to rectum and vagina is of much significance. Though their prognosis *quoad vitam* is favourable, they should be extirpated by the perineal operation or laparotomy, or by Säger's lateral perinæotomy according to their size and situation.

KROGIUS (*Arch. f. kl. Chir.*, Bd. l., p. 948), records a case of a smooth elastic tumour completely filling the pelvis and displacing the rectum upwards and to the right in a woman of 26, who for ten years had suffered from obstinate constipation sometimes persisting for weeks. After an exploratory laparotomy the tumour was removed by a parasacral operation, and proved to be a dermoid cyst of the pelvic connective tissue.

UTERINE FIBROIDS AND THEIR OPERATIVE TREATMENT.

Gow, in a paper based upon 47 cases of abdominal hysterectomy with intra-peritoneal treatment of the stump, and only one death (secondary hæmorrhage), which was read before the Medical Society of London on January 8, 1900, laid much stress on the gravity of adhesions, and recommended the application of a precautionary ligature to the outer fourth of the stump on either side, and that one or both ovaries should be left. Though probably not more than 10 per cent. of all cases call for abdominal hysterectomy to save life, the operation rescues many women from permanent invalidism.

CHAMPNEYS (*Lancet*, January 20, 1900), addressing the North London Medical and Surgical Society on October 12, 1899, said that some gynæcologists wish the same indications for operation to be accepted for myomata as for ovarian cysts, and to justify such frequent interference greatly exaggerate the danger which a fibroid tumour entails on its subject. In his opinion sarcomatous degeneration of a fibroid is extremely rare, and fatal hæmorrhage equally uncommon. Death when a consequence of such a tumour is generally due to compression

or kinking of a ureter and consequential renal disease. A large proportion of the smaller intramural or subserous tumours escape notice in hospital as well as in private practice. In five large London hospitals during nine years, there were 433 operations for myomatous tumours, with 74 deaths (17 per cent.). The low number of operations shows that severe cases for the most part were dealt with. Anyone who operates on very many myomata will have a lower mortality; the operator becomes more expert, and less serious cases are included.

Too many myomata are operated on. A vital indication, such as is given by every ovarian cyst, is hardly ever present with a myoma, each case should therefore be considered separately, and before operation other modes of treatment should always be tried. The immediate causes of operation are generally hæmorrhage pain or pressure symptoms, but as is well known, hardly ever themselves cause death. In a leading article the *Lancet* accepts Champneys' general mortality of 17 per cent., and says that medicine, though not very effective, affords substantial relief in many cases, and if it does not cure does not directly risk the life of the patient.

BUSCH remarks (*Münch Med. Wchns*, 1899, p. 268). Much as we agree with C., a too conservative practice is no longer justifiable. The mortality of his statistics is that of ten years ago.

### FIBROIDS.

LEWERS (*Lancet*, January 27, 1900), does not admit any connexion between the number of fatal cases met with in the *post-mortem* room, and the number of cases of uterine fibroids ending fatally in that large number of female out-patients. As cancer patients for whom nothing can be done are not (as a rule) allowed to die in hospital, so deaths from fibroids not operated on die, as a rule, outside.

Moreover it is the worst cases that are operated on, and would have died had there been no operation.

The subtraction of these two classes of cases unduly reduces the number of those classified as fatal cases of fibroid apart from operation.

As to the mortality of hysterectomy for fibroids, Lewers since November, 1896, has had 20 cases with only 1 death.

A. H. N. LEWERS (*Lancet*, February 17, 1900) records nine cases; one directly fatal from septicæmia, due to spontaneous sloughing of an interstitial fibroid in the posterior wall; the sloughing tumour protruded through an opening in the posterior lip of the cervix. The other cases are interesting as examples of the current methods of operating: (1) was complicated by a suppurating ovarian cyst, and the fibroid diminished very much after the appendages on both sides had been removed; (3) cystic



change had taken place, one cavity containing puriform fluid; (4) pregnancy with large subperitoneal fibroid, expectant treatment with good results; (2) (3) (9) abdominal hysterectomy with extra-peritoneal treatment of the stump; (5) and (6) piecemeal removal of sub-mucous fibroids; (8) myomectomy of sub-peritoneal fibroid.

MEREDITH (*Lancet*, January 27, 1900, p. 262). Since 1886 has had 12 deaths in 134 hysterectomies, giving a mortality of 8·9 per cent., double that of his ovariectomies. Death directly due to a fibroid growth is a very rare occurrence.

At the Chelsea Hospital for Women, 1897-1898, there were 73 hysterectomies with 7 deaths, a mortality of 12·3 per cent. Alluding to Dr. Gow's record (*ibid.*, p. 99), of 47 cases with only one death, and 39 consecutive recoveries, Meredith said he had had a series of 30 successful cases with the *serre-ncœud*, and his last 26 cases by this method were all successful; but there is a compensating average even in surgical results, and he could not share Dr. Gow's sanguine view that the mortality of abdominal hysterectomy with intra-peritoneal treatment of the stump may be reduced to 1 or 2 per cent., unless operations are to be undertaken in cases which do not require surgical interference at all.

WM. DUNCAN (*Lancet*, March 3, 1900), in commenting on a case of successful hysterectomy for a fibroid of the cervix of the five months' pregnant uterus, dissents from Champneys' conclusion, and says: "At the present time I suppose most observers would agree that the mortality from vaginal hysterectomy does not exceed 5 per cent., and in my opinion the average mortality from abdominal hysterectomy for fibroids is not more—possibly less—than this."

STANMORE BISHOP (*Med. Press*, February 14, 1900) admits that, though the menopause is always delayed, and sometimes is so to a great extent, in cases of fibroid tumours, if the patient can struggle on till that time she may, though maimed and impoverished, escape with her life; and up to 1878, when the removal of a myomatous uterus entailed a risk of 70 to 80 per cent., patient and surgeon alike shrank from operation, medical men depreciated the dangers of the actual position, and laid stress on the probable relief to come.

Now that the mortality has been reduced to from 2 to 7 per cent., it is wise to consider more closely than heretofore the actual dangers of unoperated cases, and these dangers fall into two classes; (1) those directly due to the presence of the growth itself; and (2) those which increase the risk of operation when at last it is undertaken. These latter sometimes are fatal before operation is undertaken at all, but are all avoided if surgical aid is obtained early enough.

The inherent dangers are hæmorrhage, sepsis, pressure upon



intestine (strangulation) or ureter (hydronephrosis, pyonephrosis or anuria), complication of pregnancy, parturition or abortion, and fatal cardiac degeneration. Many cases ending in death from these causes were quoted.

With regard to the second category, simply by successive hæmorrhages a patient may be so depleted as to die from shock after an easy operation; but changes take place, during delay, in the tumour and its environment, which immensely increase the danger of operation when at last interference becomes imperative. (1) Inflammatory adhesions often complicated with, if not due to inflammations of the tubes and ovaries. Meredith estimated that there was tubal disease in 54 and chronic ovaritis in 46 per cent. of Tait's cases, and Twombly that the tubes were sooner or later affected in 50 per cent. of interstitial fibroids. These adhesions greatly prolong enucleation or hysterectomy; they alter the natural relation of the parts, and lead to wounds of the gut or ureter; moreover, there is risk of infection from leakage during the removal of diseased appendages. (2) Often associated with adhesions, there is the chance of necrosis or sloughing of the tumour; (3) pressure on the ureters may cause morbid changes in the kidney; (4) cardiac disease due to persistent bleeding may affect the chances of the patient during or after operation; (5) a broad ligament fibroid may undermine and spread out the meso-cæcum or mesosigmoid, and occlusion or gangrene of the intestine may ensue on removal of the tumour. Cases are recorded.

After referring to Platonoff's case in which adhesions rendered it impossible to remove the tumour or to close the abdomen, and to the excessive difficulties of operations described by Keith and Schröder; to the fact that fibro-cystic degeneration may rapidly alter the size of the tumour, may, moreover, in a very short time lead to necrosis; to the chances not only of life but of health given by operation, the author expressed the hope that in the future we shall hear less of waiting for the menopause in these cases, and that the rate of mortality, and therefore the risk of operation, will be diminished still further by earlier, and therefore less dangerous interference.

J. WILSON, Birmingham (*Lancet*, 1900, February 3), reports a case of fibro-myoma of the uterus; left hydrosalpinx; cardiac dilatation and degeneration; total abdominal hysterectomy; death on tenth day from perforation of a latent duodenal ulcer. Dr. Wilson remarks: Simpson met with duodenal ulcer following myomectomy. Harris draws attention to intestinal perforating ulcers after Cæsarean section as recorded by Chiara.

The frequency of serious heart affections, in cases of fibroids, calls for more consideration than it has yet received.

SCHUCHARDT, Stettin (*Monats. f. Geb. u. Gyn.*, Bd. x., S. 56), successfully removed from the wife of a labourer, cyanotic with general dropsy, a nodular fibro-myoma weighing 48 lbs.; it was attached to the fundus by a fibrous pedicle as thick as a child's arm. The uterine cavity was not opened, and the woman made a most satisfactory recovery.

PURSLOW (*Midland Med. Soc.*, February 21, 1900), showed a fibroid uterus as large as at five months pregnancy, with a multilocular cyst the size of a fœtal head of the right ovary; the left ovary was also cystic. He drew attention to the frequency with which cystic disease of the ovary is associated with fibroid disease of the uterus.

At the North of England Obstetric Society, February 15, 1900, BRIGGS exhibited an almost completely calcified fibro-myoma, weighing  $5\frac{1}{2}$  lbs., successfully removed from a patient of 60 by Baer's operation (supra-vaginal hysterectomy), and a calcified fibro myoma,  $5\frac{1}{2}$  lbs., enucleated from the parametric cellular tissue of a woman of 52, who died from exhaustion on the eighth day. There was ascites in both cases.

LLOYD ROBERTS showed a calcified tumour as large as a child's head, removed from the corpse of a woman of 70.

GRIMSDALE, uterus with multiple myomata removed by vaginal morcellation.

BARTON, a pedunculated myoma by abdominal section.

GEMMEL, fibromyoma enucleated from a uterus three months pregnant; no interruption to gestation.

PAGENSTECHER, Osnabrück (*Centralb. f. Gyn.*, 1900, No. 4), opened the abdomen of a 29 year old multipara, who suffered severely from frequent desire to micturate, sacral pain, purulent discharge and obstipation. The uterus bore four different myomata, and in its cavity a six weeks' ovum. Complete recovery in five weeks.

#### VAGINAL HYSTERECTOMY FOR SMALL BLEEDING UTERINE MYOMATA.

By SHOEMAKER. *Amer. Jour. Obst.*, 1900, February.

The myomata here referred to are small ones which cause profuse hæmorrhage, and which do not give any response to palliative treatment. If the vagina is small and the uterus cannot be drawn down far enough for ligation of the uterine arteries, the operation ought to be done from the abdomen. The uterine arteries are ligatured on each side, then by strong traction the uterus is pulled down, the fibroid removed by morcellation, aided by slitting the uterus in the middle line. Each half of the uterus is then pulled into the vagina, and the upper half of the broad ligament clamped. The clamps are

removed in forty-eight hours without disturbing the gauze packing.

In the discussion on this paper, HIRST advocated the abdominal route, and BEYEA also preferred to operate by the abdomen, since there was always the possibility of curing the patient by the conservative operation of myomectomy. DORLAND preferred the abdominal method also; he had had very unsatisfactory results from Battey's operation, but great success, in small bleeding fibroids, from the administration of thyroid extract. DA COSTA thought that in many cases myomectomy could be done through a dilated cervix; if hysterectomy were called for he would prefer to operate by the abdomen. SHOBER said that he had often been able to control the hæmorrhage by the use of desiccated mammary gland of the sheep.

J. F. J.

ALTERATIONS OF THE ADNEXA IN FIBROMYOMATA OF THE UTERUS, WITH SPECIAL REFERENCE TO THE TUBES.

By DR. VICENTO GRECO, 8vo, 136 pp., 5 plates, Palermo, *Alberto Reber*, 1899.

This monograph is divided into three parts. The first deals with the macro- and microscopical alterations of the tubes and ovaries associated with fibromyoma of the uterus which has not undergone any important degeneration. The second deals with the influence of degenerations of the tumour upon the conditions of the adnexa; the third is devoted to the etiology and pathology of the various changes in the adnexa. The conclusions drawn are as follows: (1) in fibroma of the uterus the tubes and ovaries are almost always affected by changes which in some cases can only be made out microscopically; (2) the primitive alterations of the tube generally consist in discrete hypertrophy of the muscular layers, with slight hypertrophy, or in some cases merely hyperplasia, of the mucosa; (3) the hyperplasia of the muscular layers and of the mucosa of the tube is produced in the same way as hyperplasia of the uterine mucosa; (4) these alterations are generally due to chronic inflammatory processes, ordinary catarrh or sometimes suppuration; (5) an inflammatory process consecutive to endometritis may lead to atresia in the interstitial portions of the tubes even when the isthmus is pervious and even microscopically normal; hydrosalpinx was in one case attributable to this; (6) such atresia may arise either directly through inflammatory tumefaction of the mucosa or from compression exercised by a calcareous body formed in an adjacent cystic space; (7) uterine fibromyomata may be complicated by cysts in the muscular tissue in the neighbourhood of the interstitial portion of the tube; such cysts may originate from remnants of Wolff's bodies or from the tubal



mucosa or probably from the lymphatics. In one case the cyst arose from the peritoneum (Fabricius); (8) ectopic gestation in cases of fibromyoma of the uterus is a simple coincidence; (9) the macroscopical alteration of the ovaries is general enlargement with small cysts seen on the surface or on section; purulent collections are met with occasionally; (10) the histological changes usually consist in dilatation and increase of the follicles, the vessels are obliterated, with inspissation and gelatinous degeneration of their walls and proliferation of the connective tissue of the stroma; these changes finally lead to diminution and compression of the primordial follicles, to microcystic degeneration, to atresia and colloid degeneration of the Graafian vesicles, with the formation of corpora fibrosa; (11) suppuration and sloughing of uterine fibromyomata may produce similar processes in the adnexa, depending principally upon the seat of the tumour, the part of it affected and the septic nature of the change; (12) calcareous degeneration affects the adnexa either directly by compression or indirectly by inflammation, fibrocystic degeneration by compression due to rapid changes in volume or by the onset of suppuration; (13) torsion of pedunculated fibromyomata is most likely to affect the adnexa when it gives rise to inflammatory processes; axial torsion of the fibromyomatous uterus interferes with the circulation and leads to hæmorrhages from obstruction, and afterwards to the alterations caused by suppuration and of sphacelation of the tumour, and to rotation, especially of the ovary.

The causes of the adnexal changes associated with uterine fibromata are multiple, and include (a) passive venous congestion pervading the whole pelvis (varicocele pelvica); (b) concomitant endometritis; (c) chronic pelvic peritonitis; (d) direct compression by the tumour; (e) alterations in the tumour and the affected uterus, especially inflammation of the tumour and axial torsion of the uterus; and (f) in some cases (fibroma of adnexa) the same causes which produced the uterine fibroma.

FRED EDGE.

LABOUR COMPLICATED BY CONTRACTED PELVIS, LARGE  
FIBROMA OF UTERUS, AND ECLAMPSIA.

By EDWIN K. BALLARD. *Amer. Jour. of Obst.*, 1900, January.

The patient was in the first stage of labour but no progress was being made; the abdomen and pelvis were occupied by a large hard tumour with a secondary projecting portion in the right hypochondriac region. There was hardly any dilatation of the cervix. No sign of a fœtus could be discovered. The woman was unconscious, and soon after the doctor's arrival had convulsions. She was rachitic, with a contracted pelvis, the conjugate diameter being only just over two inches. There was



suppression of urine. Removal of the tumour was advised and quickly performed by the clamp method of hysterectomy. Inside the uterus was a dead fœtus weighing six pounds, the uterus and its fibroid weighed twenty pounds. Unfortunately the urinary suppression continued and the patient died from uræmic coma. This case exemplifies the dangers attendant on large fibroids of the uterus which are left alone.

J. F. J.

#### MYOMA AND PREGNANCY.

WALZER, Cologne (*Centralb. f. Gyn.*, 1900, No. 9), illustrates the complication of pregnancy and myoma by the case of a woman of 35, who had had one abortion, and came under his treatment in the sixth month of pregnancy with a large myoma. Abortion ensued, and persistent hæmorrhage led to supravaginal amputation. The source of the hæmorrhage proved to be the retained and closely adherent placenta. The woman recovered. Walzer considers induced abortion to be indicated whenever pregnancy is complicated by myoma, and the child cannot be born by the natural way without serious danger to itself and its mother, *provided* that the mother refuses Cæsarean section.

ENGSTRÖM, Helsingfors (*Mittheilungen*, B. ii., Heft 2), in a woman of 36, at the beginning of the sixth month of pregnancy, found the small pelvis almost completely filled by a myoma arising from the posterior wall of the uterus, and under anæsthesia was able, from the rectum and vagina, to press the tumour up into the abdomen. On account of the persistence of severe pain he decided to remove the tumour by laparotomy. He found that it extended very nearly to the mucosa of the pregnant womb. It was enucleated, and the cavity it had occupied was closed by suture. This tumour proved to be a myoma which had softened in its interior. The woman was delivered of twins three months afterwards, and was again pregnant a year after the operation.

TUMOURS OF THE ABDOMINAL WALLS. By OLSHAUSEN.  
*Zeitsch. f. Geb. u. Gyn.*, B. xli., 2.

Of all tumours of the abdominal walls fibromata are the most common, and Olshausen has met with twenty-two in twelve years. They were all in youngish persons who had borne children, and the origin of the tumours seemed to be connected with the child-bearing and labour.

These new growths are generally seated in the sheath of the rectus muscle, above the umbilicus always, and generally arising from the posterior fold of the sheath. They are sometimes intimately adherent to the cartilages of the false ribs, and sometimes to bones, particularly to the anterior superior spine of

the ileum. They generally grow to the size of a hen's egg, or that of the fist, but may be met with weighing as much as 1,100 grammes.

As a rule the tumour projects outwards, and not on the peritoneal side, and pushing aside the muscular fibres often lies immediately below the skin. The small volume of the tumour compared with the eminence it makes is a diagnostic sign of much importance.

When the new growth lies within the sheath of the rectus muscle it is movable laterally, and is not apt to be connected with other organs.

These tumours are hardly ever multiple, but may present themselves repeatedly in the same subject. They seldom give pain or any trouble save by their size.

They are easily removed, though generally the scissors and knife must be used to detach them from the fascia. If in such dissection the peritoneum be opened, the serosa must be stitched separately, and the fascia united by catgut sutures; the wound is then carefully dried and no drainage at all provided. Healing is by first intention.

In conclusion, Olshausen gives two interesting cases of metastasis affecting the abdominal wall: (1) An innocent ovarian cyst which was followed, six years later, by carcinoma of the other ovary, and of the abdominal wall. (2) In this case a woman had been operated on for ovarian cyst, and seventeen years afterwards Olshausen intervened for a tumour of the abdominal wall, offering all the characters of a glandular cyst; it was evidently due to inoculation at the time of the first operation.

#### ASEPSIS AND ANTISEPSIS IN SURGERY.

By PROFESSOR F. NOVARO, of Genoa. *Centralb. f. Chir.*, 1899.

Professor Novaro describes the methods of asepsis and antiseptics practised in his clinic at Genoa. The materials for use are sterilised for one hour by exposure to steam, metal instruments are boiled in a 1 per cent. solution of carbonate of soda. For disinfection of the hands, Novaro practises:—(1) five minutes' washing with soap and brush; (2) rinsing in a 10 per cent. solution of carbonate of soda; (3) washing in a 1 per cent. solution of permanganate of potash; (4) immersion in a 10 per cent. solution of hyposulphite of soda, slightly acidified and acting not only as a disinfectant but as a decoloriser; (5) immersion for ten minutes in a 1 per thousand solution of corrosive sublimate. The field of operation, which is previously cleaned and bathed with antiseptic, is treated in the same manner as the hands at the operation, except that the permanganate of potash and hyposulphite of soda are replaced by alcohol.

Novaro aims at dry asepsis in operating. The aseptic wounds are only drained when there is a *cul-de-sac* left or secondary hæmorrhage is feared; the drain is not left in more than twenty-four hours. Infected wounds are tamponaded with strips of iodoform gauze, which are renewed every three to five days. He uses nothing but absorbent dressings, gauze and wool, avoiding heavy impermeable materials. To prevent the infection of the air, the operating theatre is provided with free ventilation, the floor is washed every day, and the students' entrance to the amphitheatre is covered with wet carpets. Novaro does not operate during the lecture but afterwards, since all the auditors have influence on the asepticity of the room. He regards the face mask, head cover and beard protector as inutile; washing the head and beard every morning is enough.

FRED EDGE.

#### ANGIOTRIPSY.

MANTON, Detroit (*Med. Age*, 1900, No. 2), publishes cases of vaginal hysterectomy (2) and salpingo-oöphorectomy (3), in which he employed the angiotribe with uniformly good results, and he accords the instrument all the claims advanced by its most enthusiastic advocates. Its use avoids the pain, often agonising, which is entailed by pressure forceps, and the suffering and discomfort that may be caused by the casting off of an infected ligature. Thumin's modification is an improvement on Tuffier's angiotribe, but no doubt the instrument will in the future be made less bulky and cumbersome.

#### A NEW OPERATION FOR THE CURE OF DEEP VESICO-UTERO-VAGINAL FISTULA. By N. BARDESCU.

*Annales de Gyn.*, Paris, 1900, March, p. 196; *Centralb. f. Gyn.*, 1900, No. 6, p. 170.

The author, after reviewing the operations of Jobert, Freund and Hegar, describes his own method, which he divides into four stages:—

(1) *The Liberation and Treatment of the Uterus.*—Vaginal adhesions, if any, are freed and the cervix is brought down as low as possible. The vaginal wall is incised on the cervix on each side of the fistula so as to expose the anterior surface of the uterus. The bladder is separated from the uterus with the finger as far as the peritoneal vesico-uterine *cul-de-sac*, without opening into the peritoneal cavity if possible. The uterine cavity is then curetted and washed with a 3 per cent. solution of boric acid, the edges of the fistulous opening in the uterus are denuded and united with two or three interrupted sutures of catgut. If it be impossible thus to form a cervical canal, the



remaining portion of the cervix may be excised and the wound allowed to heal as in a case of amputation.

(2) *Division of the Vesico-Vaginal Wall and Obliteration of the Fistulous Opening in the Bladder.*—From the lateral incisions just referred to, along the edges of the fistula, the vaginal layer is separated from the vesical for about an inch. Owing to the separation of the bladder from the uterus, the latter can be brought down lower and the fistula more easily reached to obliterate it. The opening in the bladder is closed by two catgut sutures *a étages*. A purse suture under the edge of the vesical mucous membrane is first inserted. When this suture is tightened, the fistulous opening is closed, care being taken to adapt the edges. Sometimes the nature of the fistula may require modification of this suture, and a second suture, continuous or interrupted, is applied over the preceding in the muscular layer. An injection of boric acid solution may now be used to ascertain if the fistula is completely closed.

(3) *The peritoneal cavity is now opened* at the anterior *cul-de-sac* and the anterior layer of the peritoneum brought down to the lowest level of the division of the vesico-vaginal wall and secured in that position to the vaginal wall by a few catgut sutures.

(4) *Closure of the Vaginal Wound and Fixation of the Vagina to the Uterus.*—First, two sutures are inserted into the vaginal wound, the vagina and uterus are fixed by passing a suture successively through the edge of the left vaginal incision, the inferior portion of the uterus and the edge of the right vaginal incision. The vaginal incision is finally completely closed by any additional sutures which the case may require.

*After Treatment.*—A sound is left in the bladder for six to nine days, then daily catheterisation, packing of the vagina with iodoform gauze is renewed every other day; irrigation of the bladder daily. The sutures are removed on the tenth day.

P. Z. HEBERT.

#### ABDOMINAL HYSTERECTOMY.

In the course of an interesting paper on this subject at the thirteenth Congrès français de Chirurgie, RICARD states that he considers sub-total hysterectomy—as he terms hysterectomy in which the cervix is allowed to remain—is preferable to complete hysterectomy, both theoretically and practically. It is more rapidly performed, asepsis is more easily ensured, the opening in the cervix is less injurious than the larger opening when the cervix is removed, and the resultant mortality is from 4 to 4·5 per cent., as against 9·68 per cent. in complete hysterectomy. Complete hysterectomy is, however, indicated, if the cervix is diseased, and under the following conditions: metritis, myomata, cancer, and in the case of a pregnant uterus, as it is then more easy to remove the cervix than to leave it.



In cancer of the cervix he considers that the abdominal operation is to be preferred to the vaginal. It affords a greater possibility of radically removing the entire disease; it is an easier operation in advanced cases; it enables operable cases to be distinguished from inoperable ones, and it is attended by no greater risks to the patient. Removal of the retroperitoneal glands is always necessary, even in the earliest stages.

HENRY JELLETT.

#### STATISTICS OF A FURTHER SERIES OF 220 ABDOMINAL SECTIONS in v. ROSTHORN'S CLINIC.

By SCHALLY. *Präger Med. Wchns.*, 1899, No. 17.

Added to 600 cases previously published these 220 performed by v. Rosthorn since 1891 give a total of 820 with 64 deaths = 7·8 per cent., of which only 27 = 3·29 per cent. were due to sepsis. The mortality of different operations was: ovariectomies 3:239 = 1·25 per cent.; myomectomies 2:169 = 1·19 per cent. Freund's operation, 12:28 = 42·85 per cent.; ectopic gestation 2:31 = 6·45 per cent.; adnexal operations 5:165 = 3·03 per cent. Compound or combined operations 3:52 = 5·77 per cent. There were 72 exploratory incisions, 51 ventral fixations, and 13 operations for ventral and umbilical hernia without a single death. The startling mortality after Freund's operation is remarkable.

FRED EDGE.

#### EXPLORATION OF THE ABDOMEN AS AN ADJUNCT TO EVERY CÆLIOTOMY.

By HOWARD KELLY. *Annals of Gynecology*, 1900, February.

In every cœliotomy, where it does not endanger the life of the patient, the author advises a routine examination of the abdominal and pelvic viscera, for the following reasons:—Such examination will almost certainly disclose the coincidence of two or more entirely independent diseases, or reveal conditions secondary to the primary disease, due either to propagation or to mechanical causes. The examination, if negative, gives both operator and patient a more comfortable assurance that the convalescence will continue without interruption.

The order in which the structures are examined must vary with the location of the incision. With a low abdominal opening the following is adopted: the condition of each pelvic viscus is noted, then that of each hernial opening which, if a hernia exists, is sewn up from the inside of the abdomen. The vermiform appendix is then examined, and if it shows any traces of previous inflammation, removed. The ureters are next inspected. The position of the transverse colon and the

stomach are noted on account of the frequency of enteroptosis. Both kidneys are palpated, and their presence, size, form and mobility noted. A stone in the renal pelvis is easily felt. The liver and gall bladder are next examined, and with the index finger in the foramen of Winslow the common duct can be traced down for several centimetres. The spleen, the pancreas and the retroperitoneal lymph glands are palpated in order.

This extended examination is applicable to three classes of cases. (1) Those in which there is no reason to anticipate disease of any other organ, and the examination adds nothing to the gravity of the situation. (2) Those in which, contrary to expectation, on opening the abdomen no disease is found near at hand. (3) Those in which there exists a definite percentage of chances that the disease discovered at the time of operation is complicated by the affection of some other organ.

J. F. J.

#### GYNÆCOLOGICAL OPERATIONS.

J. A. MANSELL MOULLIN (*West London Med. Jour.*, April) publishes a series of 43 gynæcological operations performed during 1899, including 18 ovariectomies, 9 removals of the appendages, 3 hysterectomies, 3 myomectomies, &c., &c., with only two fatalities, one in a case of suppurative salpingitis, the other a myomectomy. Case 10 is a remarkable one. A previous operation elsewhere had been abandoned after the abdomen was opened, as the case was taken to be one of hopeless malignant disease. On April 8 Mansell Moullin reopened the abdomen, which was enormously distended with ascitic fluid, and removed both ovaries which were cystic, about the size of a large orange and covered with soft papillomatous growths which had invaded the neighbouring peritoneum. Recovery was uneventful, and the ascites did not recur; the patient nine months afterwards was reported in perfect health and up to hard work.

#### COMPRESS LEFT IN ABDOMEN AFTER LAPAROTOMY FOUND IN SMALL INTESTINE.

By MERTTENS (Dusseldorf). *Centralb. f. Gyn.*, 1900, No. 4.

A severe adnexal operation was performed on a woman of 28, in March, 1899. After five months' good health she had colicky pains in her abdomen, and Merttens found near the umbilicus a fist-sized tumour which he took for a foreign body, and on laparotomy proved to be a spindle-shaped enlargement of the small intestine which gave way during the operation, and was found to contain a gauze compress. The gut was resected with circular suture, and the woman recovered. Similar cases have been published by Rehn and by Michaux,

and Pilate noticed in one case the passage by the stool of a compress left in the abdomen six and a-half months previously.

#### BACKWARD DISPLACEMENTS OF THE PELVIC ORGANS.

F. H. WIGGIN (New York), (*Lancet*, 1900, February 17), attributes most of the displacements of the pelvic organs to injuries of the perineum in childbirth, or septic infection following abortion, gonorrhœa or the intra-uterine use of unsterilised instruments. For operative treatment of backward displacements of the uterus he prefers Mackenrodt's vagino-fixation; for that of prolapsed ovary stitches through the ovarian and broad ligaments preferably inserted by the vaginal way. For prolapse of the uterus in old and feeble women, he advocates Fritsch's method of encircling the vagina by buried ligatures.

#### VENTROFIXATIO UTERI.

GRAEFE, Halle (*Monats. f. Geb. u. Gyn.*, Bd. x., S. 1), does not operate in fixed retroflexion until he has found it impossible, after 10 per cent. ichthyol glycerine tampons, hot vaginal irrigation and hot rectal injections, &c., to restore the uterus to its normal position and to keep it there by a pessary. This paper is based upon twenty-one operations, thirteen for fixed, eight for moveable retroflexion. His practice is to insert the uterine wall through two stitches, 1 cm. apart, which are removed in fourteen to sixteen days. In his later operations he introduced his sutures, as Kelly proposes, at the back side of the uterus below the fundus, so as to suspend the organ to some extent. He greatly prefers absorbable stitches, and does not think that the operation when performed in Leopold or Kelly's way causes any impediment to pregnancy or delivery. His patients were led to seek advice by menstrual disorders, dysmenorrhœa, menorrhagia, sacral or hypogastric pain, which were always much relieved, and in a large majority of cases completely cured by the restoration of the uterus to its normal position. In one woman only the operation failed to give any relief, she was an hysterical separated from her husband. One woman died after but not in consequence of the operation, the rest got well. Graefe concludes that ventrofixation must be admitted as at least as good as any modification of vagino-fixation. The disadvantage of the abdominal wound and the possibility of subsequent hernia is more than balanced by the clear view afforded of the conditions in the smaller pelvis which are particularly apt to be complicated in fixed retroflexion; the separation of the adhesions and the exact control of hæmorrhage are under the operator's eye.



## FIXATION OF THE UTERUS AND ITS DANGERS.

KLEINWACHTER, Czernowitz (*Wiener Klinik*, 1899, Heft 2 u. 3), after a comprehensive review of 391 articles on the subject, insists on the dangers that are entailed upon women in pregnancy and labour by fixation of the uterus.

## HYSTEROPEXY IN RELATIONSHIP TO PREGNANCY AND LABOUR.

By RICHELOT, *Société d'Obstétrique, de Gynécologie et de Pédiatrie de Paris*, January, 1900.

The author considers that the dangers of abdominal hysteropexy have been magnified. If the technique is correct no troubles will follow. The uterus should be fixed to the abdominal wall by its anterior face and not by the fundus. Vaginal hysteropexy places the uterus in a more normal position, but one which is attended by great danger during pregnancy and labour, especially if the German technique is followed. Alexander's operation ought to have a considerably less hurtful effect upon future pregnancies. It is, however, an operation in which we work more or less in the dark, and see neither the pre-existing condition of affairs nor what has been done. Also the ligaments may subsequently lengthen and the displacement recur. On the whole, Richelot prefers abdominal hysteropexy as performed by Doléris, in which after opening the abdomen the round ligaments are seized three or four cms. from the uterine cornua and fixed to the lower angle of the wound.

VILLENEUVE (*Thèse de Toulouse*, 1899) considers that hysteropexy prevents the regular development of the uterus during pregnancy, and favours mal-presentations and the vicious insertion of the placenta. Anterior vaginal fixation causes dragging pains, hæmorrhages during pregnancy, and frequently abortion.

VILLEMIN (*Société de Pédiatrie*, January, 1900) records the case of a girl aged 14, in whom the elongated cervix protruded 4 cms. beyond the labia. He amputated the cervix and then performed abdominal hysteropexy with good results.

HENRY JELLETT.

## THE ULTIMATE RESULTS OF THE OPERATIVE TREATMENT OF RETROVERSIO-FLEXIO UTERI.

HALBAN, Vienna (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 122), gives a full report on the operations undertaken for the correction of backward displacements of the womb during the years 1892-1898, among the 4,000 patients with retroversion or retroflexion seen during that time at Schauta's Clinic. In the 147 cases operated upon, it was only in 88 that the displacement was the sole cause of intervention. The various methods of operation adopted fall under two heads, (1) such as fixed the uterus to



neighbouring organs and (2) such as shortened the round ligaments.

As regards permanent results it was found that even when the position was properly corrected, the troubles were not cured in more than from 80 to 86 per cent. of the cases, perhaps because various symptoms had been attributed to a retroflexion that were really due to other causes; nevertheless subjective and objective improvement generally went together. As regards the objective condition ventrofixation gave the best results; next to it, Dührssen's intraperitoneal vaginofixation, and then vaginal shortening of the round ligaments. Except in complicated retroversions, vaginal operation was always preferred to abdominal. Vaginofixation was not employed before the climacteric. The Alexander Adams operation may compete with the Wertheim-Bode vaginal shortening of the round ligaments, but Halban prefers the latter, and only admits the Alexander Adams operation when the correction of an uncomplicated retroversion is absolutely indicated in a virgin, or when an inguinal hernia has to be dealt with at the same time as the displacement of the womb.

#### OPERATIONS FOR PROLAPSE OF THE UTERUS.

STAEDLER (*Archiv. f. Gyn.*, Bd. lviii., S. 492), says that in the Liestal Canton Hospital, Gelpke has since 1890 had successful results in twenty-nine cases of prolapse by constructing a strong perineum, by a modification of Lawson-Tait's method combined in suitable cases with the Alexander-Adams operation. The author adds a historical review of the development of operations for prolapse.

#### A NEW OPERATION FOR PERSISTENT INVERSION OF THE UTERUS.

By BARTON COOKE HIRST.

*Amer. Jour. of Obst.*, 1900, January.

This operation is that of cutting the cervical muscle in two, which Dr. Hirst says can be done in a few seconds, without opening the peritoneal cavity, without danger, and with the result of immediately removing the only obstacle to replacement. The cervix is divided in the median line posteriorly, the incision being carried higher on the internal than on the external surface. In the case reported, after this was done comparatively light pressure reinverted the uterus.

J. F. J.

#### INVERSION OF THE UTERUS BY TUMOURS.

By EDGAR ALEXANDER, Dresden (*Archiv. f. Gyn.* Bd. lviii. S. 439).

In the Dresden Frauenclinic a uterus was amputated, the body of which was completely inverted by a fist-big myoma.

There was no evident atrophy or flaccidity of the uterine muscle ; there had been nothing like labour pains, but it is to be supposed that the growth of the lower pole of the tumour had dilated the cervix, that the upper pole of the tumour had interfered with the contractibility of the part to which it was attached, and that the tonus of the outside and firmer parts of the wall had led to the inversion, the weight of the tumour and abdominal pressure assisted.

#### TORSION OF THE GRAVID UTERUS BY TUMOURS.

REINPRECHT (*Wiener kl. Wchns.*, 1899, S. 784) relates a case from Chrobak's Clinic : a primipara of 40, at the end of her sixth month, was found to have a hard tumour nearly filling the small pelvis and almost immovable ; the vaginal portion lay right against the upper margin of the symphysis. In the ninth month the tumour, a fibromyoma, was reduced under anæsthesia, and passed up under the left ribs. The uterus was twisted.

#### THE RELATION OF INSANITY TO PELVIC AND OTHER LESIONS. By A. T. HOBBS. *Amer. Jour. of Obst.*, 1900, January.

This is a most important record of work done by Dr. Hobbs and Dr. Mech, in the London Asylum, where over 800 women have been under continued observation, and 220 examined under an anæsthetic. Of these 188 were found to have distinct lesions of the pelvic organs, *i.e.*, 85 per cent. of those examined, and 23 per cent. of the insane females had some complicating lesion of the reproductive system. Briefly, the pathological lesions were as follows : subinvolved uteri or endometritis, or both, in 132 cases, dysmenorrhœa or menorrhagia in 18 cases, diseased or lacerated cervixes in 62 cases, cervical polypi in 5, retroverted or prolapsed uteri in 66, new growths in 18 (16 myomatous and 2 malignant), marked disease of the ovaries and tubes in 33, and lesions of the vagina in 37 cases. Up to date 173 cases have been operated upon, the classification of which affords valuable information as to the relative influence of the various lesions in maintaining or creating mental alienation.

(1) Ovarian and tubal disease was removed in 24 cases ; a return to sanity occurred in 15, or 63 per cent. ; an improvement in 4, or 17 per cent. ; no change in 3, or 12 per cent. ; 2 or 8 per cent. died from complicating pneumonia.

(2) In 72 patients, after correction of disease of the lining, body, or neck of the uterus 33, or 46 per cent., recovered mentally ; 14, or 19 per cent. improved ; and 25, or 35 per cent. remained stationary.

(3) After correction of retro-displaced and prolapsed uteri in 47 cases, there was mental recovery in 17, or 36 per cent. ; mental

improvement in 12, or 26 per cent.; no change in the mental condition of 17, or 36 per cent.; while 1 or 2 per cent. died from hæmorrhage induced by the patient tearing away the ligatures.

(4) Extirpation of tumours, malignant and benign, was undertaken in 20 cases; there was mental recovery in 6, or 30 per cent.; improvement in 8, or 40 per cent.; 5 remained unimproved, and 1 died.

(5) Repair of injuries to the vagina in 10 cases was followed by mental recovery in 2, or 20 per cent.; by improvement in 3, or 30 per cent.; 5, or 50 per cent. showed no change.

It is of the highest importance to the preservation of the mental equilibrium that the condition of the pelvic organs should be ascertained as soon as possible when a woman presents symptoms indicating the onset of insanity.

The relative value the various lesions have in the production or in the maintenance of cerebral disturbance is of interest. The author divides them into three groups:—

(1) After treatment of inflammatory utero-ovarian disease the mental recoveries were exactly 50 per cent.

(2) In the case of utero-ovarian displacements the mental recoveries were 36 per cent.

(3) In the case of utero-ovarian tumours and vaginal lesions the mental recoveries were 26 per cent.

J. F. J.

#### PUERPERAL INSANITY.

HIRSCH (*Med. Record*, Jan. 6, 1900) denies that puerperal insanity is a specific form of alienation; though pregnancy may be a factor in the etiology of the psychoses of gestation. There should be no effort to terminate pregnancy on account of such psychoses, except when there are specific indications for such intervention. During parturition there is sometimes a transitory disturbance of consciousness, clinically a psychical epilepsy; more serious disturbance may be due to trauma in difficult labour, to anæmia and exhaustion after severe hæmorrhage, or to intoxication or uræmia, and may be manifested by acute delirium, succeeded or not by secondary psychoses. The clinical features are not peculiar to childbed. Women for a few months after delivery, more than at other times, are prone to nervous and mental disorders, but this is in no way due to lactation.

PURPURA IN CHILDBED. By DIEHL.

*Zeitsch. f. Geb. u. Gyn.*, Bd. xli., H. 2.

A VII.-para, of 36, at the beginning of the fourth month suffered from stiffness of the limbs, with loss of appetite and fever, and soon afterwards aborted. On the following day

bluish black patches crossed by lines lighter in colour were observed on her trunk, they were slightly elevated and tender, and seemed hard to the touch. The labia majora and minora were swollen and blackish blue; the urine contained albumin, blood and indican, and the woman died after four days.

Microscopic examination proved the patches to be due to vascular dilatations and hæmorrhages; there were punctiform hæmorrhages on the skin of the foetus.

The author considered the case to be one of idiopathic purpura, admitting that purpura is generally a secondary disease due to most diverse causes acting through the nervous system.

He believes that gestation predisposes to purpura, and may even provoke a symptomatic attack. It certainly aggravates the danger of the disease, which nearly always leads to abortion.

Transmission of the disease to the foetus is uncommon. Probably abortion takes place or the foetus dies before there is time for the hæmorrhages to occur.

#### CHOREA GRAVIDARUM.

By MASTIN. *Thèse de Lyon, B. M. J.*, 1900, January 6.

Generally affects young primiparæ (18 to 24 years), especially such as have suffered previously from the ordinary form, a class who are also very liable to hysterical manifestations during pregnancy. Onset gradual, or if sudden, generally owing to fright or emotion; movements may be so violent as to interfere with alimentation. Extreme constipation is common. In severer cases psychopathic symptoms may be marked, or even maniacal delirium. Opinions differ as to prognosis, which Mastin does not consider so serious as some have said.

GALLION relates a case (*Obstetrics*, 1900, i., p. 20). Fright at 11 years caused chorea. Menstruated at 14; chorea again two years later, 17; married at 21; soon pregnant; sixth month decided chorea; persistent headache; miscarriage at seventh month. Still birth. Again pregnant and again chorea. Still birth at eight months. Recovery.

#### TETANUS PUERPERALIS.

KENTMANN, St. Petersburg (*Monats. f. Geb. u. Gyn.*, B. xl., S. 527), met with a case of tetanus after abortion in the third month. The first symptoms appeared on the seventh day, and in spite of injection of serum the patient died on the third day of the disease. The author has collected forty-four cases of puerperal tetanus published since 1885, supervening in thirty after delivery at term. In twenty-six out of the thirty-four cases in which any statement is made on the point, there had been opera-



tive interference during or after labour. The symptoms of the disease appeared from the fourth to the nineteenth day—on the average upon the ninth. The mortality was 92·4 per cent.; on the average death occurred after ninety-six hours, the earliest after twenty-four, the latest after eighteen days.

Of ten cases treated with serum only one, in which the disease did not appear till late and was accordingly more chronic in its course, recovered. Seven cases do not appear to have been influenced by serum or antitoxin.

#### HEPATIC TOXÆMIA DURING PREGNANCY.

FOTHERGILL AND STENHOUSE (*Clinical Society, Manchester*, February 20, 1900) described a case of a I-para of 32, who before the end of the seventh month was affected with extreme anasarca of the legs and trunk up to the ribs. The urine was reduced to one-third of a pint per diem, turned solid on boiling and contained bile. In spite of active treatment ascites developed, the liver dulness decreased to  $2\frac{1}{2}$  inches; the stools contained no chyle. She rapidly improved after the induction of labour.

#### ECLAMPSIA.

LEWINOWITSCH (*Cbt. f. Gyn.*, 1899, No. 46) has found in the blood of 44 eclamptics, large cocci of round or oval shape and of remarkable individual mobility, which he believes have a definite connection with the etiology of the disease.

E. HERZ (*Wiener Med. Wchns.*, 1900, Nos. 3, 7, 8) concludes that there is no uniform causal factor for puerperal eclampsia. Even slightly toxic products in the blood of women in childbed are sufficient to irritate the vasomotor centres, which are then in a condition of increased excitability. Herz recommends morphia and chloroform, and also hot baths, and sees danger in too early delivery.

R. JARDINE (*v. Lancet*, January 13, p. 105) publishes details of 17 cases of puerperal eclampsia treated by saline injections, generally of 3i. : Oj. of equal parts of chloride of sodium and bicarbonate of potash, though acetate of soda was substituted for the potash salt in the last 5 cases. Five cases were fatal, one from rupture of a duodenal ulcer. Two other deaths he attributes to morphia, in which he has lost all faith.

MACVIE (*Edin. Obs. Soc.*, February 14, 1900) described a case of eclampsia succeeded, after an interval of consciousness, by profound stupor, fatal on the tenth day of the fourth puerperium. There had been stupor after the birth of the second and third children. He attributed the coma to venous congestion of the brain during tonic spasm of the chest, and recommended inhala-

tion of oxygen and venesection. In the stage of convulsions he advocated chloroform to narcotise the brain centres and allay peripheral irritation.

The *Therapeutic Gazette*, December, 1899, gives a series of articles on the treatment of puerperal eclampsia by E. P. DAVIS, Philadelphia; J. C. EDGAR, New York; A. KING, Washington; E. REYNOLDS, Harvard; R. C. NORRIS, Philadelphia; in which much stress is laid upon the importance and success of prophylactic measures. It is abstracted in the *Brit. Med. Jour.* Epitome, March 17.

#### THE PHYSIOLOGICAL RELATIONSHIPS BETWEEN THE UTERUS AND THE APPENDAGES.

By G. ROUBINSTEIN. *Thèse de Dorpat*, 1899.

The author, from a number of experiments on rabbits, concluded that the removal of one ovary sometimes caused the hypertrophy of the remaining ovary, sometimes its atrophy, sometimes no change followed. In the case of bitches marked hypertrophy always occurred, while in rabbits the hypertrophy when it did occur was poorly marked. No noteworthy changes occurred in the uterus.

The removal of both ovaries was followed by considerable atrophic changes in the uterus. The mucous membrane became thinned, its folds disappeared, the superficial epithelium and glands atrophied; while the walls of the vessels thickened, their lumen diminished. In the tubes the connective tissue of the muscular coat thickened. If the removed ovaries were fixed to the peritoneum or left free in the peritoneal cavity, in some cases they atrophied, in others they were preserved, and in these the uterus underwent no modifications.

Total hysterectomy modifies the ovaries neither anatomically nor physiologically. Various traumatisms (partial resection, &c.) inflicted on the ovary were to such an extent followed by regeneration of the ovarian tissue without any degeneration that the ovary, even when five-sixths of it had been removed, was able to regenerate itself completely. This regeneration extended to all the structures of the gland. It was especially perfect when the wound had been made aseptically. Ignipuncture was the only traumatism by means of which atrophy of the ovary could be caused in the rabbit.

HENRY JELLETT.

#### THE CHANGES WHICH OCCUR IN THE FALLOPIAN TUBES DURING PREGNANCY.

JANOT (*Thèse de Lyon*, 1899) considers that during pregnancy the tube follows the upward movement of the uterus into the abdomen, becoming at first oblique and, towards the end of

pregnancy, almost vertical. Beyond sharing in the general hypertrophy of the genital organs, it is but little modified, though it becomes straightened out; a white and yellowish fluid may appear in it, and the ciliæ of the epithelium disappear.

At term the changes are more marked. The lumen of the tube is diminished, the muscular wall is thickened, and the secondary folds of mucous membrane have completely disappeared. For a distance of 1.5 cms. beyond the uterine ostium the mucous membrane of the tube has all the characters of uterine decidua, beyond this point it retains its tubal character.

After confinement the calibre of the tube is increased, but in place of the former regular arrangement of plicæ, the lumen is filled with fragments of tissue irregularly grouped, all of which, especially the epithelium, is in process of breaking down. Janot considers that this destruction of the protective epithelium may explain the large number of cases of salpingitis observed after confinements not kept aseptic.

HENRY JELLETT.

#### A CASE OF INTERNAL OVARIAN PREGNANCY OCCURRING IN ONE OF THE GRAAFIAN FOLLICLES.

By Dr. CATHERINE VAN TUSSENBROEK (Amsterdam).

*Ann. de Gynéc.*, Paris, 1899, December.

A description of a pregnant ovary removed from a woman aged 31, already mother of five children, and with no history of miscarriage or of any serious affection of the pelvic organs, by Professor Kouwer of Haarlem, in consequence of rupture six weeks after the last appearance of the catamenia. The ovary was somewhat enlarged, the tumour protruding from its surface and formed by the ovisac was about the size of a walnut; clots of blood still adhered to its surface, and near its base the perforation was still visible.

The authoress gives a minute and elaborate microscopical description of the ovary and ovisac, and of the remains of the corpus luteum, which she differentiates by means of plates showing the relation of the maternal with the foetal tissues. From her investigation she draws the following conclusions:— (1) That the occurrence of ovarian pregnancy is a fact which cannot be contested. (2) That ovarian pregnancy means pregnancy in a Graafian follicle. (3) That as in the present case the wall of the Graafian follicle has undergone no transformation into decidual tissue, we must infer that the decidual reaction mentioned by Webster is not a *sine quâ non* condition for the implantation of the ovum. (4) That as this case presents a regular development of normal syncytium, it affords a new and incontestable proof that the syncytium has nothing to do with the uterine epithelium, but that it is derived from the foetal ectoblast.



## THREE CASES OF ECTOPIC GESTATION.

By HENRY J. KREUTZMANN AND LOIS NELSON. *Amer. Jour. of Obst.*, 1900, January.

These cases, fully reported, are respectively tubal abortion with cystoma of ovary, and tubo-ovarian abortion. None of the women experienced any sign or symptom of being pregnant; menstruation had been regular; the first seizure of pain occurred two weeks after the last menstruation in two, in the third instance at the time of the expected flow. A full pathological report is appended to each case, from which it is evident that the muscular coat was thinned at the placental site in two of the cases and hypertrophied outside that area. In the first case there was chronic follicular endosalpingitis and chronic interstitial salpingitis in the other two.

J. F. J.

## ECTOPIC GESTATION.

LEOPOLD, Dresden (*Archiv f. Gyn.*, Bd. lix., S. 557), in the fourth instalment of his contributions on extrauterine pregnancy, discusses graviditas tubo-ovarialis, and gives detailed accounts of six cases, showing that before the commencement of gestation tube and ovary were more or less blended together, and that the ovum took root at the seat of union. The cases varied from one to two months' duration to full term with dead fœtus; they were all operated on; one was fatal from peritonitis and ileus with secondary hæmorrhage from the seat of the placenta.

## ECTOPIC PREGNANCY (TUBAL).

FISCHEL, Prague (*Münch. med. Wchns.*, 1900, S. 274), reported a case of tubal pregnancy complicated by purulent sactosalpinx of the other side. When first examined the patient was feverish and collapsed after rupture of the pregnant tube; a thumb-thick tumour was found to the left of the correspondingly enlarged uterus. Fischel considered the sactosalpinx purulenta and metritis to be quite recent and probably due to infection from intrauterine manifestations, with the object of inducing abortion. The woman recovered completely in five weeks, though an opening had to be made in Douglas' pouch, and a discharge of pus took place through the cœliotomy scar.

## ECTOPIC GESTATION.

MITCHELL (*Lancet*, February 17, 1900) exhibited at the Bradford Medico-Chirurgical Society, January 16, a specimen from a case at first taken to be one of autumnal gastro-enteritis; on the fifth day hæmorrhage was diagnosed, but the patient died before anything could be done.



# ECTOPIC PREGNANCY.

JOHN PHILIPS (*London Obs. Soc.*, March 7, 1900), reported what was probably an instance of complete tubal abortion. Fœtal death at term after spurious labour. Abdominal section four to five months later. Recovery.

## PERITONEAL INUNDATION AFTER RUPTURE OF ECTOPIC PREGNANCY.

ROUTIER (*Soc. de Chir. de Paris*, March 21, 1900), reporting on a paper of MM. Morestin and Auvray, insisted on the necessity of prompt intervention, and recommended the removal of all blood effused into the peritoneum. He pointed out that to ensure complete removal the patient must be raised from the Trendelenburg position to the horizontal, as otherwise considerable quantities of blood may remain behind the liver, spleen, and coils of intestine.

QUÉNU agreed that it was better to remove the effused blood than to content oneself with arresting the hæmorrhage; not because the blood might be infected, but because the absorption of the colouring matter might be injurious and provoke auto-intoxication.

TUBAL PREGNANCY: TWO FÆTUS IN ONE SAC. HEINRICUS and KOLSTER (Helsingfors). *Arch. f. Gyn.* Bd. lviii., S. 95.

A nullipara, aged 33, with pulmonary tuberculosis, was carried off by perforating peritonitis. At the autopsy the left tube was found transformed into an immense reddish blue tumour, which extended up to the umbilicus. The sac contained two full term fœtus, one of which was completely macerated.

## SIMULTANEOUS INTRA- AND EXTRAUTERINE PREGNANCY.

HERMES communicated to the Free Surgical Society of Berlin, January 8, 1900, an instance of the above unusual combination occurring in a woman of 30, who, six months after the removal of a left tubal mole, was delivered normally of a healthy child. Gutzwiller (*Archiv. f. Gyn.* 1893, S. 223), collected 18 such cases, and Hermes added 3 others from German and 4 from American sources, making with the one now reported 26 in all. (Neale's "Digest" refers to five cases, 4 later than Gutzwiller's paper, which quotes Clarke, T., 56, ii. 590; Pennefather, L., 63, i. 688; Cooke, L., 63, ii. 39; Argles, L., 71, ii. 394.)

## RETROUTERINE HÆMATOCELE.

REGNIER (*Soc. Chir. de Paris*, February 28, 1900) has, since 1890, operated on 39 cases of hæmatocele, extrauterine gesta-

tion, or peritoneal inundation, including as hæmatoceles limited effusions of blood coincident with hæmatosalpinx. In 31 of these cases he performed a laparotomy; 6 were cases of ectopic pregnancy of from two to four months, 4 of peritoneal inundation, and 2 of these were fatal. In 21 instances, with one death only, there was simple hæmatocele.

Among the cases in which he merely incised the *cul-de-sac*, he had once to perform hysterectomy in consequence of infection of the hæmatocele. The patient died. In another case serious hæmorrhage necessitated an immediate laparotomy.

The diseased adnexa were removed from both sides of 8 of the 31 patients who underwent laparotomy. He has met with many cases in women treated for hæmatocele by simple vaginal incision, in which the recurrence of similar troubles compelled them to seek further surgical intervention.

He thinks that the results justify his opinion that colpotomy, while sufficient for small hæmatocele, is an unsafe operation for large and recent effusions of blood.

#### INDUCTION OF LABOUR FOR ALBUMINURIA DURING PREGNANCY. By COUDRAY. *Thèse de Paris*, No. 162, 1900.

As a result of recent experience the induction of labour should not be attempted for the relief of albuminuria unless the patient has been already placed on a suitable diet. To induce labour would be to provoke eclampsia. When, after a week or so of milk diet, the albuminuria remains stationary or grows worse, induction ought to be performed if the uterus is well developed; if it is not, the milk diet may be continued for a little longer. If the child is dead labour should not be induced, as the death of the child checks the albuminuria of pregnancy.

HENRY JELLETT.

#### CÆSAREAN SECTION.

REYNOLDS, Boston (*Obstetrics*, 1900, No. 1), in a paper based on 16 cases, the mother recovering in all, and the child in 14, concludes:—

(1) The indications for Cæsarean section vary according as the mother is, or is not, infected, exhausted by prolonged labour or efforts to extract the child, or the subject of serious complicating disease. (2) When the vitality is lowered by any of these causes, the maternal death rate from Cæsarean section is so high that the operation is only justifiable when the child cannot be extracted in any other way. (3) In the absence of such unfavourable conditions, and when circumstances render good operating possible, Cæsarean section is the operation of choice in cases at term in which the ordinary intrapelvic

operations are inefficient, and, on account of its greater safety to the child, may in suitable cases be preferred to the induction of premature labour.

G. COLE-BAKER (*Dub. Journ. of M. S.*, 1900, p. 10), in the fortieth hour of labour, performed Cæsarean section upon a woman parturient for the eleventh time. The true conjugate measured 6 centimetres. The child weighed 9 lbs. The patient nursed her infant from the second day. Five of the former labours terminated naturally, three with aid of forceps and two by version and craniotomy. Three sets of sutures were used to close the uterine incision, over which the omentum was drawn.

H. M. J.

#### CÆSAREAN SECTION AND PERFORATION.

FRANK (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 60) records at the Olmutz Lying-in Institution 20 perforations of the living child and 10 Cæsarean sections. In the former cases no mother was lost, but two died after Cæsarean section. Frank concludes that though the indications for perforation of the living child have been much narrowed by the success of Cæsarean section, such indications will continue to present themselves in some cases.

FREUND, Strasburg (*Berliner kl. Wchns.*, 1900, No. 8), holds that when there is no immediate danger to the labouring woman, and the conditions for surgical interference are favourable, perforation of the living child is not justifiable, and must be replaced by Cæsarean section, of which the danger is now no greater than that of a complicated delivery. He reports three cases in which several factors combined to indicate the operation. (1) A primipara, 44 years: a contracted pelvis, but still more the rigidity of the soft parts, and eclampsia; (2) a IV.-para of 43: contracted pelvis, her age, and a tumour which had led to great œdema of the intestinal wall; (3) a Cæsarean section was performed upon a V.-para of 28 with a contracted pelvis, because she wanted a live child. Freund considers that the transverse incision of the fundus has proved very beneficial.

#### CÆSAREAN SECTION IN MORIBUNDA.

PROKESS, Buda Pest (*Centrallb. f. Gyn.*, 1900, No. 9), operated on a I.-para of 28, who was brought to the hospital in an unconscious condition. The child, a prematurely developed living boy, was delivered by Fritsch's fundal incision, and did well. The mother died eight hours after the operation. The autopsy revealed thrombosis, softening of the brain substance, and pulmonary œdema.

## PLACENTA PREVIA AND ITS ANATOMY.

PONFICK, Breslau (*Archiv. f. Gyn.*, Bd. lx., S. 147), concludes from examining one placenta previa totalis and two placenta præviæ laterales (only two other cases published), the lower rim of which were closely adherent to the cervical mucosa, that: every placenta previa is, in the broadest sense, a placenta cervicalis either primary or, since a placenta previa totalis has during the latter half of pregnancy a cervical surface of attachment, secondary. Nevertheless, every placenta cervicalis need not be a placenta previa, since during the second half of pregnancy it tends constantly to move upwards and may retire beyond the limits of the cervical canal, though still attached to the cervical mucosa.

## FIBRINOUS PLACENTAL POLYPI.

LANGHANS, Jena (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 508), describes a polypus taken from a patient who died from typhus (enteric). It contained decidual cells, but no foetal elements. Its base corresponded to the entire seat of the placenta. In its interior there were numerous convoluted arteries with much thickened adventitia and luxuriant intima. The external layers of the polypi were evidently the older, the internal the younger, so that the growth of the polypus was to be attributed to hæmorrhage from the arteries in its interior. The author opines that the origin of such polypi may perhaps be referred to the persistence at the seat of the placenta of arterial remnants that are usually cast off with the placenta.

## HÆMATOMATOUS MOLE.

HERZFELD recently (*Münchener med. Wchns.*, 1900, No. 12), exhibited at the Vienna Medical Society a specimen of the above from a woman of 22. About eighteen months ago she found herself pregnant; about two months later all symptoms of pregnancy vanished at once, but the catamenia did not return (an occasional loss of a little blood may be attributed to erosion of the portio). When Herzfeld examined her the uterus was enlarged, but there was no other sign of existing pregnancy. The facts stated by the woman made him suspect a molar pregnancy, and he introduced a bougie, which led to the expulsion of the entire ovum containing an embryo 11 mm. in length. There were numerous protuberances filled with clotted blood on the inner surface of the membranes; there was no liquor amnii. This condition has been described by Professor Breus as a typical morbid entity under the name hæmatomatous mole, or subchorionic tuberos hæmatoma of the decidua, a view that Herzfeld prefers to that of Jul. Neumann, who considered the formation to be a fleshy mole caused by primary hæmorrhage.



## COLPOPORRHEXIS.

BELITZ-HEIMAN, Moscow (*Centralb. f. Gyn.*, 1900, No. 5), records a case of spontaneous rupture of the uterus and vagina in a 23-year-old secundipara. Version and extraction of child (and placenta) out of the abdominal cavity. Expectative treatment, washing out the vagina with normal salt solution and tamponade with iodoform gauze. Recovery after thirty-one days.

DANIELS (*N. Y. Lancet*, December, 1899) reports a case in a I.-para of 25; labour appeared to be a natural one and was not prolonged—no instruments or ergot were used. The rectum was not torn, but there was profuse hæmorrhage, which was controlled by hot douches, the wound being too high for convenient suture. The case did well.

## RUPTURE OF THE UTERUS.

HERBERT SPENCER (*London Obstetrical Society*, Jan. 3, 1900) reported four cases of rupture of uterus successfully treated by gauze packing. Abdominal section in his opinion is rarely necessary; and unless the injury to the broad ligaments endangers the vitality of the uterus it should not be removed. All incomplete and most complete ruptures should be treated by packing with iodoform gauze.

PEARSE (*B. M. J.*, February 17, 1900) reports a case of spontaneous healing of a ruptured uterus: there had been version and extraction on account of placenta previa. It was impossible for him, from the circumstances of the case, to perform laparotomy, which, in spite of the favourable issue of expectant treatment, he considers the only proper treatment.

## MECHANICAL TREATMENT OF ATONIC UTERINE HÆMORRHAGE.

SCHWERTASSEK (*Centralb. f. Gyn.*, 1900, No. 7) recommends Arendt's method of downward traction, by means of bullet forceps applied to the lips of the womb, as a means of arresting atonic bleeding from the uterus. He believes that by permanent traction in this way he saved the life of a woman who, in the fifth month of a binovular twin pregnancy, was undoubtedly bleeding to death.

## SEPTIC UTERINE EMPHYSEMA.

HALBAN (*Monats. f. Geb. u. Gyn.*, B. xi., Heft 1) proposes the above name for an unusual form of disease which affected a woman of 41. Two days after the manual detachment of the placenta in a bad confinement, her abdomen was distended by the blowing out of her uterus like a balloon; there was tympanitic percussion all over the organ and, as tympania uteri could be excluded, the condition was diagnosed as due to collec-

tion of gas in the uterine walls. Later, on palpation of the abdomen, a peculiar deep-seated crepitation could be felt. The woman died on the fourth day, under symptoms of severe sepsis. *Post mortem*: the uterus nearly filled the abdomen, an enormous quantity of gas being developed in its walls. Bacteriological examination disclosed mixed infection of streptococcus pyogenes and a bacillus of the group B. emphysematis. Uterine crepitation need not depend on bacterial development of gas, but may be caused by atmospheric air which has found its way under the peritoneum—or before delivery by emphysematous decomposition of a dead foetus—or it may be simulated by the adherence to the uterus of a loop of intestine.

#### PUERPERAL INFECTION.

R. JARDINE (*Lancet*, January 24, 1900) describes three fatal cases of unusual origin: (1) infection from a finger wound; (2) extreme sepsis admitted moribund after five days in labour; (3) infection from a retroperitoneal abscess.

MONTINI (*Gaz. d. Ospedali e d. Cliniche*, 1900, No. 21) records an interesting recovery from severe puerperal fever, in which a phlegmonous inflammation of the broad ligament led to various metastases in the right pleura and in the bladder, intestine and pelvic peritoneum.

MACHARG (*B. M. J.*, Feb. 17, 1900) discusses 57 cases of puerperal infection, of which 31 were fatal (21 autopsies). Half the fatal cases were I.-paræ, and operative measures had generally been required for delivery. He recommends washing out the uterus and a loose tamponade of iodoform gauze; quinine and serum injections were of no great use. Curetting was badly borne, was followed by rigors and rise of temperature, and was given up except for retained fragments of placenta or membranes. Serotherapy, tried in 9 cases in which the streptococcus was present, was of no benefit at all in 7; its effect was very doubtful in another, and not certain in the remaining one. The author hopes more in the further development of surgical treatment, especially in the timely abdominal extirpation of the uterus and sometimes of the adnexa also.

WEBBER (*ibid.*) reports a case favourably influenced by Burroughs and Wellcome's serum.

ANDERSON (*ibid.*) also gives a case (and 2 of erysipelas) in which anti-streptococcic serum was beneficial.

#### PEROXIDE OF HYDROGEN.

TERRIER, QUÉNU and MICHAUX (*Soc. de Chir. de Paris*, March 14, 1900) concurred in attributing much benefit to the action of interstitial injections of peroxide of hydrogen in gan-

grenous septicæmia, but none of the cases quoted were gynæcological. REGNIER also concurred, but recommended dilution, as the "pure oxygenated water" might cause sloughing. TERRIER thought not, if properly prepared.

PLATON has in two instances found peroxide of hydrogen useful in arresting uterine hæmorrhage (*v. Practitioner*, 1900, p. 441).

A. DWORETSKY (*Therapeutische Monatschrifte*, No. 2, 3, 1900) has (like others) obtained such satisfactory results from the use of Credé's silver ointment in septic processes, depending upon infection by staphylococci and streptococci, that he does not hesitate to pronounce this mode of treatment as a specific against these severe forms of disease.

#### VAGINAL INJECTIONS IN LABOUR AND CHILDBED.

KRÖNIG (*Münch. Med. Wchns.*, 1900, No. 1), from clinical observation of 1,100 patients, one half of whom were treated with prophylactic injections (sublimat 1 : 2000) and the others without, concludes that such injections are, to say the least, unnecessary. The uniformity of treatment in all other respects excludes any possible source of error.

#### GRAVE PUERPERAL INFECTION WITH ACUTE PERITONITIS, VAGINAL HYSTERECTOMY. CURE.

By C. MARIANI. *Archivio di Ost. e Gin.*, 1900, No. 1-2.

This treats of a patient 24 years old, who was delivered at the end of 1898, and who came to the hospital at Massa. After having used all the conservative methods of treatment, Mariani decided to perform vaginal hysterectomy, the woman being *in extremis*, and forty-six days having now elapsed since the confinement. The uterus having been removed, a great quantity of purulent fluid escaped from the peritoneal cavity. The post-operative course was very stormy, owing to the condition in which the patient found herself. Fortunately the patient recovered perfectly.

FRED EDGE.

#### FORCEPS IN MORTUA.

FLEISCHMAN, Buda Pest (*Centralb. f. Gyn.*, 1900, No. 4), tells of a 30-year-old primipara with mitral insufficiency, who collapsed while the forceps were being applied. The child, asphytic when extracted, was easily revived, and remained alive. The mother could not be saved.

NEUMANN, Berlin (*Centralb. f. Gyn.*, 1900, No. 10.), reports a case in which a living female child was extracted by forceps fifteen minutes after the death of the mother. The girl lived to be herself delivered by forceps twenty years later.

He also reports a case in which, before term, he delivered a woman with disease of the heart and extreme dyspnœa, while standing up, by perforation of the head and extraction. The dyspnœa continued after delivery until incisions had been made to relieve the œdema of the legs. He thinks the woman would have died immediately if she had been laid down, though he characterises the delivery of a woman in such a condition in the standing position, as horrible.

#### RHYTHMIC ENDOUTERINE FŒTAL MOVEMENTS.

By E. FERRONI.

*Annali di Ostetricia e Ginecologia*, 1889, December.

The author arrives at these conclusions which are not final:—During the last months of pregnancy the greater number of women have special rhythmic movements which may be expressed graphically, and which are due solely to fœtal action. These movements of a rhythmic nature have no connection with the ordinary quick movements. They appear at various times in the twenty-four hours, are periodic and vary both in frequency and duration. They appear during labour and in febrile attacks of the pregnant woman with the same characteristics as in the normal condition. They are seen equally in primiparæ and in multiparæ. Two types may be distinguished—the jerky and the undulatory. From their location and extent they correspond with the movements of the fœtal thorax.

Very possibly the rhythmic movements of an irregular character are in connection with a fœtal sob or sigh, and the undulatory are in connection with superficial respiratory movements in the uterus.

FRED EDGE.

#### MEASUREMENT OF INVOLUTION OF UTERUS.

At the Glasgow Obstetrical and Gynæcological Society, 1900, January 24, MACLENNAN introduced this subject by pointing out that the progress of involution cannot be gauged by the quantity of lochial discharge. He regards the placental site as neither more nor less than a granulating ulcer. The lochia are the natural discharges from a raw surface; but the lymph reaching the surface from the deeper tissues in this instance necessarily contains fat, since the muscular fibres of the area from which it drains are undergoing rapid fatty degeneration. He adopts the method of measurement suggested by Stevens and Griffiths. He takes the crest of the pubes as the fixed point, locates the fundus by palpation, and measures the distance with a ruler. The usual fallacies are guarded against by having the bladder and rectum empty, and the uterus in the middle line and hardened by a little massage. For purposes of registration on a



temperature chart, that line corresponding to  $100^{\circ}$  is taken as a base, and each degree represents an inch of fundus elevation. The daily measurements and temperature are recorded on the same chart.

In primiparæ, after expulsion of the placenta the fundus stands 4 inches above the pubic crest. Within the next eighteen hours the uterus relaxes and the fundus rises from 1 to  $2\frac{1}{2}$  inches. After this comes a gradual though remitting fall. In multiparæ the involution curve is pitched 1 inch higher than in primiparæ. Among causes given which produce modification in the curve are: (1) an atonic condition of the uterus leading to its distension with blood clots; (2) retention of any considerable portion of placenta; (3) the clinical condition known as *sapremia*, in which there is fever, very often factor of the lochia, and a large flabby uterus; (5) endometritis, metritis, septic thrombosis, cellulitis, salpingitis, peritonitis, or a general septicæmia, all hinder or stop involution. Endometritis causes a large increase in the size of the uterus.

Thus: A rise in the fundus without rise in the temperature points to a mechanical cause for the elevation. A gradual but irregular rise in the temperature, with a large increase in the size of the uterus, is indicative of irritating contents in its cavity. A high fever with little but sustained rise in the height of the fundus, indicates, besides mischief in the uterus, a more serious lesion outside it. If no change in involution accompanies fever, its cause is not uterine.

H. M. J.

#### PURULENT MASTITIS NEONATORUM.

F. A. WINDER (*Med. Press and Circ.*, Dec. 20, 1899) has met with purulent mastitis in three newly born girls and in one boy. The inflammation is frequently unilateral. Lactation has also been observed in several infants, male as well as female, soon after birth. The quantity secreted is small, never oozes from the nipples; is most frequent in first born—witches' milk. Inflammation due to interference.

#### LACTATION STATISTICS.

G. F. BLACKER (*Med. Chron.*, February, 1900) caused 1,000 women attending the Extern Maternity Department of University College Hospital, a month after confinements, to be questioned as to whether they were suckling their infants, how many children they had had, how many had been suckled and for how long. Of the 1,000 women it was found that 747 had suckled (fed by the breast alone for seven months) all their children; 214 had suckled a certain number (average 62.7 per cent.) of children; 39 had not suckled, but of these, 13 had

sufficient milk to have done so; in 2 cases the amount was doubtful, and 5 of the remaining 24 women gave definite reasons, such as pelvic cellulitis, for having fed artificially.

Blacker then quotes statistics on lactation by Buchmann, Zoepfer, Pistor and Wiedow, and finally maintains that amongst the London poor it is quite the exception for a woman to be prevented from suckling by insufficiency of milk.

H. M. J.

#### THE ACARDII AND THEIR KIN.

SCHATZ (Rostock) (*Archiv f. Gyn.*, Bd. lx., Heft 1) continues his work on the placental circulation of uniovular twins, and discusses the origin of acardii from the contraction at an early period of the allantoic vein, or later of the umbilical vein, or from pronounced asymmetry of the third common circulation of the two fœtus. In the hemi-acardii one portion of the vascular system is occupied by the blood circulating in the sound child, and this intruding blood-stream can pass into veins of the invaded child through its heart.

#### PLURAL BIRTHS.

BENNHEIM (Philadelphia) recently communicated to a Medical Congress in that city. A woman, at Mayfield, Kentucky, was delivered a few weeks previously of five male infants alive and weighing between 4 and 5 pounds. Though healthy in appearance, all died at two days' interval at the end of a month.

The proportion of plural to singular children is: twin, 1 to 80; triplets, 1 to 7,910; quadruplets, 1 to 371,126.

## SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

*Opinions as to pathology or treatment expressed in the following abstracts are not necessarily endorsed by the editors or their collaborators. Any Fellows of the Society who may be willing to give the editor-in-chief regular assistance in the preparation of this summary are requested to communicate with him. He will be greatly obliged by having his attention drawn to any important work published at home or abroad; particularly so by receiving condensed abstracts of such work from the authors themselves.*

### TWENTY-FIFTH ANNUAL MEETING OF THE AMERICAN GYNÆCOLOGICAL SOCIETY,

Washington, May 1, 2 AND 3, 1900.

ABSTRACTED BY J. FURNEAUX JORDAN, *Annals of Gynecology and Pediatrics*, May and June, 1900, and *Philadelphia Medical Journal*, May 5, 1900.

#### *First Day.*

ON "AN OPERATION FOR PRIMARY VAGINAL CARCINOMA, APPLICABLE ALSO TO CANCER OF THE RECTUM IN WOMEN, by WILLIAM P. PRYOR.—This operation removes as thoroughly as possible all the diseased area. "An incision from the pubis to the umbilicus is made and the internal iliac arteries and the obturator vessels are ligated with kangaroo tendon, the bladder is dissected from the anterior uterine wall and the vagina opened anteriorly. The uterus and appendages, with the entire rectum, are later removed after the actual cautery has been used to char the cancerous mass. After the excision of the rectum and the periproctal tissue, an artificial anus is formed near the normal site." The advantages of this operation are:—The preventive hæmostasis renders the field of operation comparatively dry. Injury to the cancer field is avoided till hæmostasis is secured and the cancer charred. There is removal of all organs in which the recurrence is apt to take place from above downward. The artificial anus is established near the normal site.

In the course of the discussion MUNDÉ did not think that such a bloody and radical operation would repay, as the benefit

to the patient is slight and the recurrence inevitable. SUTTON, of Pittsburg, had little faith in radical operations for malignant disease of the genitals. VAN DE WARKER thought that disease which did not recur could not have been cancer. MONTGOMERY disbelieved in radical operation, since it is impossible to determine how extensively the glands and perimetritic structures may be involved. LAPHORN SMITH held that "unsuccessful operations deter other patients who might be relieved from being operated upon." DUDLEY heartily approved of the method, as the best that can be done for these desperate cases.

"THE REMOTE RESULTS OF CONSERVATIVE OPERATIONS OF THE OVARIES AND TUBES," by Dr. BURRAGE, Boston. Under the heading of "Conservative operations" are classed all those in which one ovary or one tube, or a portion of one ovary or a portion of one tube was left behind, and cases of suspension of the ovaries are excluded. An analysis is given of 104 patients operated upon before March, 1899; 19 could not be traced, these cases in the table are therefore 85, and they are divided into: more severe cases where pus was present in tube or ovary, where tubes and ovaries were extensively diseased and abundant adhesions were present; less severe, with mild or moderate degrees of inflammation and few or no adhesions. The conclusions drawn are as follows: (1) Conservative operations are advisable in all cases where the ovaries and tubes are not hopelessly diseased in all parts of their structure, except on patients who are near the menopause, or on those who have pronounced gonorrhœa of long standing, or malignant disease. (2) On a patient near the menopause (over 35) with ovarian or tubal disease of any considerable degree of severity, it is generally wiser to perform complete removal, with or without hysterectomy according as the uterus is diseased or not. (3) In cases of well-marked gonorrhœa of long standing, especially if the patient is to be constantly exposed to reinfection, and both tubes are seriously diseased and closed, total removal with or without hysterectomy is the operation of choice; (4) but if the patient thoroughly understands the likelihood of another operation being necessary at some future time and yet wishes to take the chances in the hope of preserving the function of menstruation, conservative operation is sometimes permissible. (5) Even in the presence of gonorrhea, if one tube be patent and healthy in appearance and there be enough healthy ovarian tissue to preserve, a conservative operation ought to be performed. (6) With present methods of performing resection of the tubes, if at the time of operation both tubes are found closed, subsequent pregnancy is not to be expected. (7) In severe grades of inflammation of the appendages, irrespective of causation, should the ostium abdominale of one tube be patent, the prospect of subse-



quent pregnancy after the preservation of a portion of ovary is about one in four and a quarter, or  $23\frac{1}{2}$  per cent. (8) In the less severe grades of inflammation, under similar conditions of tube and ovary, the prospect of subsequent pregnancy is about one in two and a quarter, or 44 per cent. (9) In women who have borne children, in both classes, subsequent pregnancy may be expected in 35 per cent., but in previously sterile women in only 5 per cent. (10) If it is necessary to remove both ovaries, there is no advantage in preserving any tubal tissue, but, except under the conditions above mentioned, some ovarian tissue should be preserved in every case.

A. W. JOHNSTON, in a paper on the "Internal Secretion of the Ovary" said: "There is not an iota of proof that the ovary has any other function than the manufacture of eggs. The ovary is in no sense a gland. Its epithelium is arranged for the purpose of being cast out and lost, and is not placed so that its secretions, if it has any, could be absorbed either by ducts or blood vessels. Anatomically, the ovary does not resemble the suprarenal, the thymus or the thyroid gland. The thymus is a lymphatic gland, the thyroid and suprarenal have a rich supply of blood vessels so arranged that each epithelial cell is closely approximated to a venous radical, thus providing for a rapid absorption of whatever secretion its cells may make. The ovary has a true duct through which its epithelium when cast out passes off *en masse* to the outer world.

"If it is a lack of an internal secretion that causes the nervous disturbances of the menopause, why is it that the little girl does not have them? Why is it that a delayed menstruation in a child-bearing woman will produce identically the same symptoms as those of the menopause?" If a woman's menstruation is delayed, for any reason except pregnancy, she has symptoms closely approximating those of the change of life. From his large experience the author concludes that the troubles with the menopause, both natural and artificial, are due to a faulty oxidation and excretion.

"TECHNIC, INDICATIONS, AND ULTIMATE RESULTS OF SUTURING THE ROUND LIGAMENTS TO THE VAGINAL WALL FOR RETROVERSIONS AND FLEXIONS OF THE UTERUS," by HIRAM N. VINEBERG. It is impossible here to describe fully Vineberg's operation. The vesico-uterine pouch of peritoneum is opened, not simply by a transverse incision, as in vaginal hysterectomy, but the opening is made a large one by a vertical incision through the vaginal wall in the anterior median line and separation of the two flaps thus made. The uterine fundus is drawn into the vagina, and the appendages, one after the other, are inspected, and if necessary, operated upon. The round ligament of each side is then secured in two silkworm

gut sutures, the fundus is returned into the abdomen, the sutures are passed through the vaginal wall and tied while the uterus is held in the anteverted position. The incisions, vaginal and peritoneal, are sutured. Fifty cases are tabulated, in thirty-two of which some surgical work upon the appendages was found necessary. All the cases recovered. One was an absolute failure, and in two instances of congenital retroversion there was, in a few months, a tendency to return to the original condition. Ninety-four per cent. were cured. Three women went through normal pregnancies and had easy labours. A fourth is in her ninth month of pregnancy, and has so far done well. The operation is indicated in all mobile retroversions and flexions of the uterus in which it is necessary to perform some operation; also in such as are associated with some prolapse of the uterus; in all adherent retroversions and flexions in which the uterus only is adherent, and in cases where the uterine condition is associated with moderate disease of the appendages. The operation should not be done in congenital retroversions, nor when the broad ligaments are infiltrated and shortened by inflammatory disease, when the appendages are extensively diseased, nor in complete prolapse of the uterus.

#### *Second Day.*

A paper was read by title, on "A Comparison of Vaginal and Abdominal Operations," by RICHELOT, of Paris, an abstract of which we hope to publish in our next number.

"ANASTOMOSIS OF THE URETERS WITH THE INTESTINES, AN HISTORICAL AND EXPERIMENTAL RESEARCH," by REUBEN PETERSON.—The experimental work which forms the basis of this paper was undertaken with the view of studying the changes resulting from anastomosing the ureter with the intestinal tract, and of determining whether the procedure could with safety be employed in human beings. The author concludes that:—(1) The primary mortality of uretero-intestinal anastomosis both in experimental work on animals and in man is exceedingly high; (2) the best technique is that requiring the least amount of suturing of the ureters themselves; (3) all efforts to prevent ascending renal infection in animals, or in man, where the ureter has been implanted without its vesical orifice, have proved futile; (4) it is impossible to determine in advance the extent of the infection which will result from uretero-intestinal anastomosis. The patient may die in a few days of a pyemia, or in a short time of pyelonephritis, or in rare cases, may recover from the infection with resulting contracted kidneys; (5) the operation is unjustifiable, either for the purpose of making the patient more comfortable, as in exstrophy of the bladder, vesico-vaginal or uretero-vaginal fistula, or for malignant disease of the

bladder ; (6) the results of uretero-intestinal anastomosis through the formation of vesico-rectal fistulæ have not been favourable up to the present ; (7) the success of Frank's experimental work in vesico-rectal anastomosis justifies the expectation that the future results of this operation will be more satisfactory ; (8) the primary mortality of uretero-trigono-intestinal anastomosis is low for an operation of this magnitude ; (9) while it cannot be denied that ascending renal infection may occur after this operation, the infection, as a rule, is of such a type that the chances of the individual's overcoming it are good ; (10) hence the operation of implanting the vesical flap with its ureteral orifices into the intestine is a justifiable surgical procedure ; (11) there is no valve guarding the vesico-ureteral orifice ; nor does the circular muscle layer of the ureter, nor the bladder muscles themselves, act as a sphincter ; (12) the rectum tolerates the presence of urine, acts as a good substitute for the bladder, and good control over the anal sphincter can be maintained.

"THE EVOLUTION OF MY TECHNIC IN THE TREATMENT OF FIBROID UTERINE GROWTHS," by HOWARD A. KELLY.—We quote from the abstract in the *Annals of Gynecology* : "Dr. Kelly, with the aid of drawings and photographs detailed his method, particularly in dealing with very difficult cases, such as large adherent tumours or intraligamentous fibroids. There are three ways of dealing with these tumours and meeting the complications : (1) by a median sagittal bisection of the uterus with the tumour ; (2) by a coronal bisection of the uterus in the cervical portion ; (3) by a bisection of the tumour alone. The situation and anatomic relation of the tumour should be thoroughly studied after the abdomen is opened, before beginning operation. The dangers to be avoided are brought about by atypical cases ; the hæmorrhage may be excessive and uncontrollable, prolonged operation and injuries to the intestines and ureters may jeopardise the patient. In all these cases the principle of the operation is the same, and the best method of enucleation is first, to seek out, isolate and ligate the ovarian vessels of one side, then to expose and tie the uterine vessels of the same side, then to cut across the cervix and clamp the opposite uterine artery, then the round ligament, and lastly the ovarian vessels.

"AN APPRECIATION OF KELLY'S METHOD OF REMOVING FIBROIDS OF THE UTERUS," by LAPHORN SMITH.—The operation is by far the best, is almost devoid of danger and is absolutely effective. In comparing Kelly's method with Doyen's, the author thinks that Doyen's has an advantage in that the tumour is pulled away from the bladder and ureters on both sides, while in Kelly's it is so only on one side, but on the other hand Doyen's has the objection of opening the vagina, thereby he thinks, increasing the time of anæsthesia, the loss of blood



and the risk of infection. He is opposed to leaving the ovaries and tubes. "In the majority of cases the appendages are diseased, and we run the risk of the whole success of the operation being marred by leaving in organs which will sooner or later cause more symptoms than the fibroid tumour itself." He is strongly opposed to myomectomy, except in the case of a single polypus or a single pediculated subperitoneal tumour. All fibroids should be removed as soon as discovered.

J. F. J.

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A CRITICAL SUMMARY OF RECENT LITERATURE ON THE LOCALISATION, DIAGNOSIS, PROGNOSIS, AND TREATMENT OF GONORRHOEA IN WOMEN. By JOHN G. CLARK.

*Amer. Jour. of Med. Science*, January and April, 1900.

This paper consists in a study of Bumm's work on gonorrhœa in women, and a comparison of Bumm's opinions with those of Neisser, the discoverer of the gonococcus. The gonococcus has, no doubt, been evolved by special environment and opportunities, and no doubt with time its power could be attenuated or reduced to the comparative impotence of the general herd of germs.

Noeggerath's dictum of gonorrhœa, "once infected always infected," is approximately true, and no immunity from re-infection by the gonococcus can be acquired.

Bumm thinks that a large proportion of cases terminate in complete recovery, but such recovery can hardly be demonstrated since the mere absence of gonococci, even after a dozen examinations by microscope and culture, proves nothing.

Gonorrhœa, according to Bumm, is essentially a disease of the epithelial layers, and does not go deeper. The gonococcus penetrates between and into the epithelial cells, and there is a free transmigration of leucocytes into the irritated area. The epithelium is lifted up and finally shed, and in this way the disease is arrested, since the cocci have no power of entering the connective tissue layers beneath the epithelium. The patches where the disease lingers are spots with some epithelium left, and containing colonies of cocci. The vulva, vagina and vaginal cervix are covered with simple pavement epithelium and not, as is supposed, with mucous membrane, and consequently except in young children and old women, where the epithelium is delicate and easily affected, they resist the cocci much better than the urethra and cervix.

Bumm says that only the ducts of Bartholin's glands are affected, the terminal acini being immune owing to the germicidal action of their secretion. The duct may become occluded and form a pseudo-abscess, but the acini remain free and are



simply crushed into the underlying connective tissue. Later on germs other than gonococci may cause a true abscess of the gland and tissues around it.

In some cases evacuation of the abscess may be followed by complete healing and a restoration of Bartholin's gland to normal action. These are cases of pseudo-abscesses or retention cysts; in others the abscess quickly re-forms, and nothing but complete extirpation is of any use. These are cases of pyogenic germ infection, and one acinus is attacked after another.

In the uterus Bumm says that the endometrium alone is attacked by the gonococci; the muscular layers suffer simply from infiltration by leucocytes. In 50 per cent. of the cases of uterine gonorrhœa endometritis glandularis was present with free growth of the glands. The glands in the cervix are hardly ever invaded by gonococci. The Fallopian tube is affected like the uterus, and Bumm does not accept the presence of germs in the muscle wall of the tube.

Perioöphoritis and encapsulation with adhesions may occur, and infection of a follicle or corpus luteum may lead to ovarian abscess.

In spite of some recent and almost conclusive investigations, Bumm holds that the gonococci cannot cause general peritonitis. No doubt the chief cause of general peritonitis and of purulent processes is mixed infection. Any immunity acquired by the mucous membrane is very fleeting, and is effective only against the gonococcus of the infected individual.

*Localisation.*—The urethra is affected in practically all acute cases. The symptoms are unusual tendency to urination and a feeling of irritation before and after the act. There is some burning from external denudations. The symptoms generally last from three to four weeks, and the urethra has usually recovered in from six to ten weeks. Chronic troubles, such as papillary excrescences about the meatus urethræ and red patches in the urethra, sometimes remain. Gonorrhœal threads may be passed in the urine.

The lesions about the vulva are secondary and not usually specific in nature. Small condylomata may form and be mistaken for syphilitic growths. The lesions in the internal genitalia are also well described.

*Diagnosis.*—After certain precautions drops of secretion are taken with a sterile platinum wire from the urethra, Bartholin's ducts, and the cervix. Methylene blue solution is used as stain. The gonococci will be in the leucocytes, but a dozen searches may have to be made before obtaining proof. Even if germs are not found the case may still be one of gonorrhœa, and this is the great weakness of diagnosis by the microscope, apart from defects in skill and experience.

*Prognosis* does not exist so as to bear any definition. Each case must be taken alone, and if the uterine tissues and appendages are involved true recovery may be said to be if not impossible, almost unknown. An interesting point is that pregnancy occurs so often, among 108 pregnant women at Heidelberg thirty had gonococci in the genitals.

The *treatment* in the acute stages must be absolute rest. Ichthyol is the best of new remedies, and from one to five parts to 100 may be used as an injection. It has no disagreeable sequelæ. Silver salts are still extensively used.

NEISSER advocates immediate germicidal treatment. BEHRENS, the inspector of prostitutes in Berlin, is more conservative and passive. Local cleanliness, general treatment and free urination are never sufficiently insisted upon.

F. E.

#### THE CAUSES OF THE IMMUNITY OF THE VAGINA WITH REGARD TO VENEREAL INFECTION.

BARBIANI (*Giorn. ital. delle mal. veneree e della pelle*, 1., 1900), in discussing the cause of the relative immunity which the vagina enjoys from syphilitic and primary gonorrhœal infection, records a case which he considers points to the fact that this immunity is due to the acid reaction of the normal vaginal discharge, and not to causes which are usually invoked, such as thickness of the vaginal mucous membrane, &c. For a profuse leucorrhœa—dating from her confinement—the patient had been treated for some time by injections of bicarbonate of soda and tannin. Symptoms of a recent syphilitic infection declared themselves, and on examination with a speculum, he found on the anterior vaginal wall a copper coloured infiltrated area, which he considered to be the primary sore. The vaginal discharge was alkaline. Under suitable treatment the secondary manifestations disappeared, and the chancre changed into a small indolent infiltration. Barbiani considered that only the loss of the normal acidity, caused by the profuse leucorrhœa and the continued use of alkaline injections, permitted the formation of a primary sore on the vaginal wall.

H. J.

#### VAGINAL CYSTS.

PINKUS, Dantzie (*Centralb. f. Gyn.*, 1900, No. 20), after describing four cases in which advice was sought on account of vesical troubles and which were cured by resection of the cysts, points out that the greater number of vaginal cysts give rise to no symptoms and either escape notice or are discovered by accident. He refers the origin of these cysts to the ducts of Gartner and Wolf, and for other points refers to J. Veit's dissertation on these cysts, in the first volume of his recent handbook.

# RETROSTRICTURAL ŒDEMA OF THE FEMALE BLADDER.

KOLISCHER, Chicago (*Centralbt. f. Gyn.*, 1900, No. 17), draws attention to congenital stricture of the female urethra apart from previous gonorrhœa, syphilis or injury. It may give rise to severe pain in consequence of œdema of the internal os of the urethra, which is distinctly recognisable with the cystoscope, by which in some cases one may also find solitary ulcers. The only rational treatment of such elastic strictures is to divide them by an internal urethrotomy. The pain and all other consequences are rapidly relieved.

# THE VALUE OF HOT BATHS IN THE DISTURBANCES OF THE MENOPAUSE.

GOTTSCHALK (*Sem. Méd.*, June 13, 1900) states that hot saline baths, at a temperature of about 40° C., lasting for about twenty minutes, and taken every evening at bedtime, constitute an excellent means of combating the night attacks of heat and sweating from which so many women suffer at the time of a natural or post-operative menopause; the favourable effects are usually manifest at the end of the first week, and twenty-six to twenty-eight baths are sufficient to cure the trouble altogether.

H. J.

# THE ANATOMY OF THE UTERUS IN INFANCY AND CHILDHOOD.

V. MANDACH, Bern (*Virchow's Archiv.* Bd. clvi., S. 94), reports that among 80 cases examined, Wolf's duct was found in 32, Rieder's muscular band (the remains of the muscular elements left after the obliteration of the duct) in 14. The epithelium throughout the length of the canal is for the most part in a single layer. The mucosa was always well developed in the cervix, in the cavum of infants up to five years of age the glands made little appearance, in 3 of 8 uteri of girls between ten and sixteen years old the glands in the corpus uteri were few and small but well-formed. In a single instance in a child of five, there was a diverticle of the mucosa of the fundus in the form of a small cyst lying almost immediately below the serosa. On the external surface of the portio gland-like canals with a poor cylindrical epithelium, were found in a few cases, but true glands in none; on the inner surface of the lips of the os some glands with goblet cells in the squamous epithelium were met with in one case. Immediately above the limit between cylindrical and squamous the mucosa was much fissured, exhibiting structures like papillæ—and even regular papilloma. The limit between the epithelia was very often definite, the squamous epithelium falling precipitously away from the single layer of cylindrical cells; but generally the cylindrical cells became two



and then three deep and passed gradually into the squamous form.

Polypoid formations were present in 35 of the 80 cases, in the neighbourhood of the inner os; they were prolongations of the plicæ palmatæ, unaltered in many instances in structure, but as a rule, at all events in the many instances of club-like enlargement of their extremities, formed like true polypi. They had no glands and seem to undergo spontaneous involution.

#### UTERINE IRRITATION AND NERVOUS PYREXIA.

LEVEN (*Rev. de Méd.*, March, 1900) relates his experience of cases of nervous or hysterical elevation of temperature in women. The course followed by this condition is very variable. In some cases the elevation persists for months, and may at times reach a height of 106° F. In other cases its course is more acute, resembling that of typhoid fever, or it may assume a pseudo-meningitic type, or be intermittent, resembling ague. All Leven's cases occurred in young women in whom menstruation was either painful or irregular, and in all, the onset of the pyrexia was associated with the menstrual disturbances. He concludes, therefore, that nervous elevation of temperature may be due to irritation of the uterine nervous system, and that to obtain a cure this irritation must be removed. H. J.

#### UTERINE HÆMORRHAGE.

OSTERMANN, Hamburg (*Deutsche. med. Wchns.*, 1900, No. 13, 14), reports on a series of thirty cases of meno- and metrorrhagia, in which he has employed and always beneficially, a mixture of salol and antipyrin as originally recommended by Labadie-Lagrave. Equal parts of both drugs are heated together in a test tube and form a brownish viscid fluid which while still hot is introduced by means of a Fritsch's aluminium probe covered with wadding into the previously washed out intrauterine cavity. In most cases a single application arrested the hæmorrhage.

#### ENDOMETRITIS DOLOROSA.

PINKUSS, Berlin (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 908), points out that he some time ago published cases similar to those recently described by Sneguireff as endometritis dolorosa, and now sets forth the type of the disease on the basis of four other cases. In his experience it generally affects young women—married and unmarried—and he attributes some influence in its origin to mental shocks (*e.g.*, sudden death of a husband, or lover). He cannot corroborate Sneguireff as to the painful points on the abdomen, but the reason for this may be, that prior to Sneguireff's paper, his attention was not directed to their



detection. The pronounced tenderness of the endometrium on the touch of the sound is characteristic of the disease. As a rule, only certain localities (fundus and tubal insertions) give rise to the attacks of pain. The use of the curette brought recovery; a glandular hyperplasia could generally be found in the débris.

#### ENDOTHELIAL TUMOURS OF THE UTERUS.

POHORECKY, from Landau's Clinic in Berlin, writes (*Archiv. f. Gyn.*, Bd. lx., S. 252): an endothelial growth of the posterior lip of the cervix, bigger than a walnut, sprang exclusively from flat cells of the lymph spaces (not from the lymphatic vessels) of the tissue of the portio, and was explained histologically as endothelioma interfasciculare, morphologically as carcino-sarcoma interfasciculare. In its subsequent course and extension of the tumour—the growth of the tumour from itself, tissue infection of the neighbouring tissue, and dissemination by the transport of tissue elements. The patient is now well, two and a half years after total extirpation.

#### ELECTROTHERMIC SOUND.

SCHÜCKING, Pymont (*Centralb. f. Gyn.*, 1900, No. 16), gives an illustrated description of an instrument used by him in amenorrhœa, endometritis, cervical catarrh, erosions, gonorrhœa and such like, and adapted to apply gradually raised temperature to the mucosa for such duration as may be wished, without caustic effects or any danger to the patient.

#### ATMOKAUSIS, MEASUREMENT OF TEMPERATURE.

PINKUS, Dantzie (*Centralb. f. Gyn.*, 1900, No. 25), found by experimental investigation that a fall does occur in the conducting tubes, but only of a few degrees. If the steam below the return tube be temporarily shut off, the temperature in the uterus quickly rises as high as that in the kettle. Obliteration can be brought about in this way. In conclusion, Pinkus declares that both in his own hands and those of others, atmokausis has proved to be a valuable means of dealing with infected matter in the uterus.

#### SEROUS INFILTRATION OF THE PARA-UTERINE CONNECTIVE TISSUE.

EHRENDORFER, Innsbruck (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 803), on the removal of a large uterine myoma extending up under the costal arches, found a collection of serous fluid in the left ligamentum latum; it had unfolded the whole of the ligament and found its way from there into the left paranephron. This exudation was clearly due to congestive œdema caused by the

large myoma; it had followed the way taken by injections made to study the pelvic connective tissue, and one may suppose had come on quite gradually during the growth of the tumour.

#### RETROFLEXION AND ITS TREATMENT.

By BIERMER. *Magdeburg Medical Society*, 1900, March 8.

The symptoms of complicated retroflexion are more often due to the complications than to the displacement. Only when there is inflammation does retroflexion directly cause trouble. Uncomplicated retroflexion of long standing in women who have hard physical work may require treatment and then, especially in virgins, operation is more helpful than pessaries. As Fritsch has said, pessary treatment is an art that requires more skill, more medical knowledge, more patience, more experience, than any operative method. The Alexander-Adams' operation, excellent in its way, is adapted to but a limited number of cases of absolutely mobile retroflexion; it is rivalled by pessary treatment, and there are dangers and uncertainties in its execution which often force the operator to change his plans.

Biermer considers Olshausen's the best of all current methods of ventrofixation, and does not hesitate to pronounce it the most suitable method of operation whether the retroflexion be mobile or fixed, since no interference with pregnancy or labour has been traced to it.

Vaginofixation should not be done on a woman during her sexual life. The constant mania for devising new methods of vaginal fixation, to be remodelled and tried on hundreds of cases and then abandoned; the way in which these methods are eulogised as certain in results and simple in execution, Biermer declares is the saddest page in the history of modern gynæcology.

Fortunately, as regards the operative treatment of retroflexion, we are becoming more conservative, and clearer limits are admitted as to our knowledge as to what is requisite.

WEIDENBAUM, Riga (*Petersb. Med. Wchns.*, 1900, No. 11), discusses the indications and technique of pessary treatment, and also the successful results of the Alexander-Adams' operation (twenty cases) which the author looks upon as the most suitable of all existing methods of intervention. In a tabular form he gives twenty cases operated on in Knorre's Clinic by the Alexander-Adams-Kocher method, clinically with excellent results, except in one case when suppuration occurred on both sides, and another when there was hysteria. Anatomically there was hernia double-sided in one, and on one side in another case, but the uterus was in good position.

Commenting on this article, SENTENIS (*Ibid.*, No. 16) insists

upon the efficiency of the prolonged assumption of the knee-elbow position, in reducing even incarcerated gravid retroflexion.

#### RETROFLEXION OF THE GRAVID WOMB, INCARCERATED, URACHUS FISTULA.

UNTERBERGER, Königsberg (*Monats. f. Geb. u. Gyn.*, B. xi., S. 657), relates that a girl of 23, after a fall suffered from hypogastric pains and fever, and some four months later from retention of urine, till suddenly there was a discharge of urine through her navel. This fistula persisted and was followed by vesical catarrh and later by the expulsion of shreds of the cervical mucosa. When consulted at this time Unterberger discovered retroversio-flexio uteri partialis incarcerata. Reduction followed the enlargement of the gravid womb, but the woman aborted. The urinary fistula healed rapidly, and the vesical catarrh yielded to treatment. The author supposes that the urachus had not completely closed, and that under the extreme distension of the bladder the urine was forced into and ultimately through it, rupturing the navel at the last.

#### THE TREATMENT OF RETROVERSION OF THE GRAVID UTERUS.

PINARD (*Sem. Méd.*, May 30, 1900), in discussing this subject at the Académie de Médecine, stated that he considered that the irreducibility of the uterus was almost invariably due to the presence of adhesions or of tumours of the adnexa. He sums up the treatment as follows: Commence by ensuring the complete evacuation of the bladder and rectum, usually the displacement will then become spontaneously corrected. If not, attempt manual reduction from the vagina, with or without an anæsthetic. If this fails, the introduction of a distended rubber bag into the rectum is the only form of instrumental treatment which is allowable. In the case of an irreducible retroversion, it is necessary to have recourse to abdominal section in order to break down the adhesions and to directly replace the uterus. If there is manifest evidence of gangrene of the bladder mucous membrane, vaginal cystotomy must be performed.

H. J.

#### ALEXANDER'S OPERATION.

EHRENDORFER, Innsbruck (*Wiener klin. Wchns.*, 1900, No. 14), discusses the history of this operation, and then describes the technique of its performance, laying stress on blunt dissection and exposure of the external ring, central search for the round ligament after slitting the inguinal canal, drawing out the liberated ligaments as far as possible, abundant shortening of the 12-15 cm. of the ligaments; hernia-proof closure of the inguinal canal by Bassini's method, the ligaments being secured



in their normal course; complete hæmostasis; suture with thin silk. The method is free from danger, causes no impediment to childbirth, and is worthy of wider acceptance than it has yet met with, especially in Austria.

#### ALEXANDER-ADAMS' OPERATION—AFTER EFFECTS.

MURATOW (*St. Petersburg. med. Wchns., Beil.*, No. 5, 1900) describes five cases in which shortening of the round ligaments was followed by unhappy results. In two premature labours came on because the round ligaments had been shortened so much that the fundus uteri could not rise high enough in the abdomen; in each case there was very difficult labour, subinvolution of the uterus and endometritis, and one case died from sepsis. In two other cases Muratow discovered as a result of the Alexander-Adams' operation an incarceration of the ovaries by cicatricial bands between the uterus and anterior abdominal wall. In the fifth case the Alexander-Adams' operation failed to relieve the displacement, and hysteropexia abdominalis anterior was afterwards necessary. The author, while acknowledging the importance of the Alexander-Adams' operation in suitable cases, would greatly narrow its application—exhaustive consideration of all existing anomalies and possible results should always be first undertaken and especial caution is necessary in young women who may become pregnant after it.

#### INVERSIO UTERI.

VOGEL, Würzburg (*Zeits. f. Geb. u. Gyn.*, Bd. xlii., Heft 3), relates a case of a I.-para delivered by forceps, in which spontaneous inversion occurred under the eyes of the physician. In deep chloroform narcosis and the knee-elbow position, reposition was effected and the childbed was uneventful. Vogel describes two cases of chronic inversion, 100 other cases of inversion already published; 47 per cent. were due to intervention of some kind, only 9 per cent. were certainly spontaneous. The case now recorded is an additional proof that contrary to the opinion of some authors spontaneous inversion, though undoubtedly very unusual, does occur, a fact of much forensic importance. The only indispensable conditions seem to be great relaxation and softness of the uterine muscular tissue.

#### PRIMARY DESMOID CYSTS OF THE BROAD LIGAMENT.

FUCHS, Kiel (*Archiv. f. Gyn.*, Bd. lx., S. 297), describes desmoids of the broad ligament obtained by operation and one fibro-myoma of the ovarian ligament. The former are very vascular and inclined to softening. The abdominal route is best for their extirpation. The proper topographical significance in doubtful cases can only be ascertained by determining the components of the pedicle and their reciprocal arrangement.



## PELVIC HYDATIDS.

GRÄUPNER, Breslau (*Centralb. f. Gyn.*, 1900. No. 16), reports a case of secondary hydatid tumour of the pelvic connective tissue cured by vaginal operation. The primary tumour had been enucleated after laparotomy out of the left broad ligament when the patient was 31; a small portion was left behind from which in the course of eight years a new tumour, the size of a fist, developed and pressed upon the left back part of the vaginal vault. Gräupner opened the sac with the Paquelin, dragged out part of the cyst, and stitched the remainder to the vaginal vault, inserting afterwards an iodoform tampon into the cavity. Complete recovery in three weeks.

## THE TREATMENT OF PELVIC PERITONITIS.

STRATZ (*Zeits. f. Geb. u. Gyn.*, xlii., 1) is a strong believer in the efficacy of conservative and palliative measures in diseases of the adnexa and pelvic peritoneum. In more than 1,000 cases he has only found it necessary to operate twenty times, and in five of these cases the indication for the operation was some complication (myoma, &c.). He does not consider that massage alone will bring about the desired termination, but, supplemented by other proceedings, it facilitates the absorption of hæmatomata and the remains of chronic inflammations, particularly of adhesions. On the other hand, ichthyol has always given him excellent results. He applies it either to the vagina, to the uterus in weak solution, or on compresses to the abdominal wall.

For some time Stratz has used injections of hot water. Out of 18 cases treated in this manner, the majority were cured in from ten to fifty-one days. He recommends that the vulva be protected by a special kind of speculum, that the water be at a temperature from 48° C. to 50° C.; that at least 4 litres be used at a time, and that the patient afterwards rest for from one to two hours. During the injection the patient ought to be in the elevated dorsal position, with the hips raised, and after it is finished, a tampon of iodised glycerine should be introduced into the vagina. The author has, in this way, obtained rapid and satisfactory results in puerperal or gonorrhœal infections of the adnexa, especially in the acute forms. In tuberculous infections the method is of no value, but Stratz believes that one can obtain, at any rate, the symptomatic cure of all adnexal infections by these conservative methods. Puerperal infections afford the most favourable prognosis. Operative intervention is only necessary in tuberculous and in a few cases of old gonorrhœal infections.

H. J.

PELVIC PERITONITIS AND POSTERIOR COLPOTOMY.

V. LINGEN (*Petersb. Med. Wchns.*, No. 10, 1900) states, as a result of his experience of cases of pelvic peritonitis in which pus has formed, that he considers that purely medical means, such as the application of ice, &c., are indicated as long as the abscess does not bulge downwards into the vagina. If, in spite of this treatment, associated with rest in bed, the abscess does bulge downwards, posterior colpotomy is indicated. He has rarely found it necessary to evacuate the pus by any other route. Out of 26 cases which required operation, 15 of which were complicated with adnexal disease, only 4 did not justify colpotomy; 22 were operated on by this method—3 died.

H. J.

ON THE DECREASE IN ABDOMINAL SECTIONS DUE TO VAGINAL LAPAROTOMY.

By A. DÜHRSSSEN, reviewed by GESSNER, Erlangen.

*Münch. med. Wchns.*, 1900, No. 22.

This work, embracing the experience which the author has accumulated during the past eight years by 503 cases of colpo-cœliotomia anterior, is intended to combat the various objections that have been made to the different methods of operating by the vagina, and by propounding the advantages of these methods to diminish the number of abdominal sections.

After a short historical introduction the method is described in detail. Great importance is given to the independent suture of the peritoneum. Vaginofixation of the uterus is effected by a single silk-worm gut thread passed through the anterior wall of the uterus at the level of the tubal insertions.

Dührssen gives the following table of his vaginal cœliotomies :

	Cases.	Fatal.
Vaginofixation of the uterus for retroflexion ... ..	359	6
Vaginofixation of the lig. rotunda for retroflexion ... ..	35	0
Vesicofixation of the uterus for retroflexion ... ..	6	1
Adnexal operations and operations on the antelected uterus...	73	5
Extirpation of the adnexa for tubal pregnancy the uterus being in antelexion ... ..	13	1
Vaginal cœliotomies which were completed by neutral cœliotomy or vaginal hysterectomy... ..	16	2
Vaginal Cæsarean section... ..	1	0
	<u>503</u>	<u>15</u>

By the use of silk-worm gut and independent suture of the peritoneum a perfectly safe result should be attained in vaginofixation, a success that will not be affected by subsequent pregnancy, labour and childbed. The interference with labour so much feared after vaginofixation is not met with provided that the operation is performed exactly in the way described. It has seemed to Dührssen in many cases that conception has been directly promoted by vaginofixation.

The indications for vaginal laparotomy are thoroughly discussed. Most gynæcologists will perhaps think them too comprehensive, especially with regard to the treatment of retroflexion and of myomata. It is, to say the least, unfortunate that Dührssen should have chosen to support his comprehensive indications Neugebauer's black list of the evils due to pessaries. The improper use of curative measures, in themselves harmless, may doubtless cause injury. But who can excogitate all the ill that may be, nay, unfortunately, already has been caused by the improper use of vaginofixation? Nor is Dührssen's evidence that the smaller myomata should be dealt with in this way sound. Everyone is aware that very small tumours occasionally cause such serious trouble as may indicate their removal. But the number of such tumours is immeasurable, compared with that of the myomata small, or even of quite considerable size which give no trouble at all, or so little that by most operators their removal would not be thought of. It is going quite too far to remove small tumours because they may, perhaps, cause serious trouble later on. What would the reputation of a surgeon be who laid down the law that every indifferent, unimportant fibroma, lipoma or atheroma must be removed, because in one case some trouble had arisen or some malignant degeneration supervened.

No one denies that in many cases diseased adnexa may be removed by the vaginal way, but to adopt this route for larger and moreover adherent, tumours will always be hazardous, and as Dührssen's book shows clearly enough, even the most skilful operators will not, in doing so, be spared unfortunate results.

The indications Dührssen gives for artificial sterilisation by resection of the tubes (twenty-six cases) are open to grave objections. Very few will be able to convince themselves that they ought to follow his example.

But every gynæcologist will read Dührssen's book with interest, and every one, even though differing from him on many points, and especially as to the indications for operation, may learn much from him, though the constant egotism and the effort to represent vaginal laparotomy as a simple affair becomes tiresome.

Dührssen's deserts in regard to vaginal operations are undoubtedly very high, but a book like this one is only too well adapted to lead the less experienced to over-estimate the relief that may be afforded by vaginal interference, and the freedom of the method from danger. It is only by practice and experience that anyone can arrive at a tolerably sure judgment as to the cases that may be dealt with by the vagina, and can learn to exclude those in which that way is uncertain, unsafe, and even dangerous, and in which, therefore, the abdominal way should



be chosen. An over-enthusiastic description of the advantages, and especially of the simplicity of vaginal intervention, can only lead to over-confident operations, the evil consequences of which must bring a reaction. Considering the undoubtedly great advantages of vaginal interference over abdominal in suitable cases, such a reaction would be much to be regretted.

Dührssen compares his 3 per cent. mortality with the 5 per cent. admitted by Lawson Tait for his laparotomies, but this is misleading. The cases were by no means similar ones. Most of Dührssen's operations were for retroflexion, in which the conditions were uncomplicated. His mortality in other cases, including some complicated ones, was higher than Lawson Tait's.

#### FIFTH SERIES OF LAPAROTOMIES AT HELSINGFORS.

HEINRICIUS (*Finska Läk. Handlingar*, January, 1900) gives the following statistics for the year ending July 5, 1898:—

*Myomotomy*, 23 cases, 14 with retroperitoneal treatment of the stump by Chrobak's method, five enucleations, one by Zweifel's method; two supravaginal hysterectomies, and one extirpation of the tumour from a rudimentary bicorned uterus; *ovariotomies* 33, and one *parovariotomy*; one laparotomy for separation of ovarian and tubal adhesions, one for hæmatoma of Douglas' pouch, one for shortening the round ligaments. For prolapse, 14 *ventrofixations* combined in 11 with vaginal plastic operations; one *salpingostomy*, and 13 cases of *ovario-salpingectomy* for inflammatory affections of the adnexa or for tubal pregnancy; four *salpingectomies* for tubal pregnancy, and one case of *nephrectomy* for angiosarcoma. There were only four deaths (1) a tubal pregnancy with putrefied fœtus—peritonitis existed before the supravaginal hysterectomy and removal of the fœtal sac, and the woman died two days after operation; (2) another patient died twenty-eight days after ovariectomy, from cancer of kidney and peritoneum and pulmonary tuberculosis; (3) septicæmia carried off the woman who underwent myomotomy by Zweifel's method (in five days) and (4) one case of ovariectomy died, *four days after operation, from peritonitis*.

MEUSEL, Gotha (*Monats. f. Geb. u. Gyn.*, Bd. xi., S.) 699, tells of a laparotomy with unusually difficult asepsis, in a woman of 50. Fifteen months previously an attempt to remove a papillomatous ovarian cyst had been abandoned on account of firm adhesions, and after extracting the greater part of the papillary masses in it, the cyst had been attached to the abdominal wound. Of course the masses grew again, putrefaction took place in the cavity, and the woman became extremely depressed. Meusel, after thoroughly cleansing the cavity, cut round the wound, turned the skin into the hole, which he then stitched



up. When again everything had been thoroughly disinfected, he opened the abdomen above the upper end of the tumour, separated the adhesions without much difficulty and removed the tumour. The huge wound in the abdomen could not be completely closed and tampons had to be inserted, but the woman had recovered perfectly in five months.

#### LAPAROTOMY DURING PREGNANCY.

NUNEZ, Havana (*El. Prog. Med.*, May, 1900) reports the following cases:—

(1) *Hydramnios*.—Multipara of 37. Abdominal tumour. After being suspended for fourteen months, the catamenia had returned during the last five, but shorter and scanty compared with the former discharges; no sympathetic trouble indicating pregnancy; collum exceedingly movable and softened, abdomen much enlarged and very tense. Under an anæsthetic an elongated tumour the size of a duck's egg was made out, and was movable by the external hand everywhere below the umbilicus. Exploratory laparotomy (August 10) disclosed a cystic tumour, which proved to be the uterus enormously distended, with walls so thinned as to resemble those of a cyst, and extending two fingers' breadth above the umbilicus; a small elongated body floated within the tumour. Iversen, Pozzi, Tavignot and Olshausen have been similarly misled in the diagnosis of hydramnios. The abdomen was closed by three layers of suture, and abortion expected, but there was no interruption to gestation, the woman's troubles disappeared, the wound healed satisfactorily, and a fine boy, 11 pounds in weight, was born in the latter half of January, the quantity of amniotic fluid being very moderate.

(2) *Umbilical Hernia, irreducible and adherent*.—A multipara of 34, sought advice for a hernia which had resulted from her third labour eight years previously, and in subsequent child-bearing had increased in size till it reached that of the head of a child of two years old. She suffered such pain as to deprive her of all courage for her coming labour and the recollection of all she went through at the last, a year and a half ago, induced her to submit to a radical operation which was successfully performed on September 16, by resection of skin, a large portion of the ring, the hernial sac and omental adhesions between ligatures. A little albuminuria appeared three days after operation, but disappeared under milk diet. She rose in a fortnight with the wound well healed and without further troubles; in February, a boy more than eight pounds in weight, was born, labour not in the least affecting the abdominal cicatrix.

## HYSTERECTOMIA RAPIDA.

STAPLER, S. Paulo (*Centralb. f. Gyn.*, 1900, No. 14), some two years ago advised that in total extirpation of the uterus hæmorrhage should be secured by special clamps, so that the operation might be completed in a few minutes. Stimulated by the angiotribe of Doyen and Tuffier, he has now had constructed upon the screw principle forceps for clamping the broad ligaments that he considers far surpass those of Doyen, Thumin, Zweifel, &c. The advantage of his screw forceps is, that it is light, powerful, exercises a high pressure and compresses the whole of the broad ligament at once, without any chance of the tissues slipping out. Moreover, the instrument is adapted not only to abdominal myomectomy, but to vaginal total extirpation, and to the temporary control of the vessels in the operation for ectopic gestation. He has as yet had no opportunity of testing the instrument on the living.

## OPERATIVE ASEPSIS.

QUÉNU (*Sem. Med.*, May 2, 1900) at the Société de Chirurgie, strongly insisted upon the impossibility of obtaining perfect sterilisation of the hands, and on that account advocates the wearing of gloves. He thinks rubber gloves to be superior to thread gloves. If gloves are not worn no second case should be operated upon within forty-eight hours after a septic operation, but if they are the surgeon may even perform autopsies with safety.

H. J.

## THE CONSERVATIVE SURGICAL TREATMENT OF UTERINE MYOMATA.

OLSHAUSEN, at the German Surgical Congress (April, 1900), said that not so very long ago one used to hear that if the uterus was extirpated the ovaries were no longer of any use, and the question whether the ovaries were taken away or left behind was made to depend entirely on the difficulties of the operation. Yet it is a very important matter to preserve them, to avoid the omission symptoms which appear, and are the more violent the younger the patient is, often embittering her life for many, many years. On this account he has always considered it a duty in cutting out the uterus or a fibroid tumour, to leave an ovary behind. Similar consideration, whether in operating on a myoma cervicis one might not leave the entire uterus and ovaries behind, led him in operating on a myoma of the cervix larger than an ostrich's egg, to do so, merely sewing the corpus uteri to the vagina.

Gynæcologists of the present day generally limit the field of enucleation—in fibroid tumours—to solitary growths. In the

years 1887 to 1899, Olshausen performed twenty-seven enucleations, and believes that most people have come round to this method, because supravaginal amputation is always more dangerous. He would, however, wish the indications for enucleation to be so enlarged as to embrace cases in which several myomata are present, and small ones must be left behind, provided they should at the same time be limited to women near the menopause. He has even performed enucleation in young women when they would not wish to give up all hope of a family. After enucleation the irregular bed of the tumour must be sewn up with catgut in tiers. As to the question how far myomata require surgical treatment at all, he is more conservative than most. He has operated in only 16½ of all he saw—many surgeons read a percentage of 41 per cent.

#### FIBROMYOMA AND PREGNANCY.

HOFMEIER, Würzburg (*Zeits. f. Geb. u. Gyn.*, Bd. xlii., Heft 3), some time ago declared that the prevailing opinion as to the unfavourable influence of uterine fibroma upon pregnancy and labour was not justified. Fraenkel has recently questioned this, and Hofmeier now, on the ground of further experience, defends his opinion, having investigated the influence of myomata upon conception, fecundity and pregnancy in 550 cases of myoma. Of the married women among these cases, 26·7 per cent. were sterile, but in very few could the sterility be attributed to the myoma. The average number of pregnancies in the women who had borne children was 3·6, and only 22 per cent. of the 550 had been pregnant once and once only. Hofmeier recognises the fact that among patients with myomata, an unusual number of marriages are sterile primarily or secondarily, but diverts the question etiologically, asking how it is that so many unmarried women, women sterile altogether, or after their first confinement, suffer from myomata. The omission of conception may very well favour the development of myoma, the hereditary congenital disposition to which is about the same in all women, a causal relation between myoma and conception might so exist, but in a sense opposite to the one generally supposed. He adheres to his views as to the influence of myoma on the course of pregnancy, and save in most exceptional cases, rejects any operative interference during gestation—supporting his views by numerous tabular arrangements of his cases.

#### MYOMA, MISSED LABOUR AND PLACENTA PREVIA.

HARTZ, Carlsruh (*Monats. f. Geb. u. Gyn.*, B. xi., S. 670), gives the following case: Towards the close of the second pregnancy, of a woman known for more than two years to have a myoma, shortly after a slight hæmorrhage, the membranes



ruptured although there had been no pains. The edge of the placenta could be felt through the inner os which just admitted the finger. Labour did not go on. The myoma lay close to the brim and caused some deviation of the presenting head, and three days later, during which there were no pains to speak of, the child was dead. When eighteen days had passed since the waters broke, it was decided to deliver the woman, and on examination, as the myoma had been forced partially into the slightly dilated os and formed an absolute impediment to delivery, the tumour was enucleated piecemeal, and the mouth of the womb divided. Traction on the head having failed, an arm was brought down, but this had to be amputated before the much macerated fœtus could be extracted. The partially adherent placenta was taken away, a cervical laceration was sewn up, and the woman got well without any fever.

CARCINOMA OF BARTHOLIN'S GLAND. By G. TROTTA.  
*Archivio di Ost. Gin.*, 1900, April.

Malignant disease of the vulva is comparatively rare; according to Schwarz in 1,147 cases of cancer of the genitalia, the vulva was affected in only 30. The author has found 10 cases of cancer of Bartholin's glands recorded in literature, but attributes this small number rather to want of enterprise and care than to absence of such cases. Excluding the cases of Fritsch, Martin and Wolff, as insufficiently reported, he draws the following conclusions from the other 7 cases. Cancer of Bartholin's glands has so far not been observed as a bilateral lesion; four times it was upon the right side, thrice on the left; its volume has been from the size of a prune to that of a fist; the ages of the patients have varied from 28 to 70. The form of the cancer has varied, melano-carcinoma, tubular carcinoma, medullary cancer, and cancrroid (author's case).

In Martin's case only, were the inguinal glands involved. And even when there was local recurrence after operation, there was return in the glands in two cases only.

It appears therefore, that cancer of the vulvo-vaginal glands has a tendency to invest itself in a very thick connective tissue stratum which retards its diffusion to the neighbouring tissues, and renders its prognosis relatively benign. The prognosis is certainly much worse when the inguinal glands are involved and must of course be extirpated; but whenever cancer of the glands of Bartholin can be diagnosed with certainty, even when the inguinal glands are not felt or seen to be involved it will be advisable systematically to remove them, as is done in cancer of the tongue and of the uterus, and as Kelly and Jacobs advise in uterine cancer.

F. E.



REMOVAL OF THE CANCEROUS UTERUS BY THE VAGINA.

HOWARD KELLY (*Bull. Johns Hopkins Hosp.*, 1900, March), points out that during the last year it has been shown that glandular metastases, so important in mammary cancer, are relatively much less so in uterine disease, and are, as a rule, only observed in the later stages. More careful research has proved that cancer of the uterus extends progressively through the tissues from its cervical focus, and in order to divide the bases of the broad ligaments as far as possible from the diseased cervix, catheterisation of the ureters is an essential preliminary to every radical operation.

After a thorough curettage of the diseased area the vagina is cut through on all sides and separated from the bladder, so as to expose the vesico-uterine peritoneum, which is divided; the base of the bladder may, if necessary, be cut off and left attached to the cervix. The recto-uterine pouch of the peritoneum is then divided and the uterus remains attached by the broad ligaments alone. A gauze pack having been inserted behind, the uterus and cervix are pressed against it, the anterior wall is caught step by step with Museaux forceps, and drawn down through the anterior incision until the fundus appears at the vaginal outlet, and the uterus is bisected from above downwards. The corpus of one side is seized by a stout Museaux forceps, and after the other half of the organ has slipped back into the vagina, a second forceps seizing the cervix of the same side, the corpus is divided from the cervix by cutting from within outwards. When the division is complete the uterine vessels are clamped in the exposed cellular tissue and the corpus is pulled further out, and the round ligament, and finally the uterine cornu are also clamped, and the one half of the body is then removed. The body on the other side is treated in the same way. Ligatures are then applied instead of the clamps. The adnexa are removed after the corpus. The removal of the body of the uterus in this way gives so much room that it is easy to remove the cervix on the side least implicated, keeping the rigid catheterised ureter under touch and cutting as wide of the cervix as possible.

To complete the operation the remaining half of the cervix of that side on which the broad ligament is most affected has to be dealt with, and the aim of the operator is, with perfect control of the vessels, to extirpate this remainder, giving it as wide a berth as possible. This may sometimes be done by ligature, in others by Skene's electro-hæmostasis or the igni-extirpation as practised by Mackenrodt.

If the ureter lies well clear of the diseased tissue, and is itself unaffected, it may be dissected out and left intact. But

in many cases the operator must, without hesitation, cut off the ureter above the disease, and proceed with the wide enucleation of the new growth as if the ureter did not exist. When the enucleation is over the ureter may be readily turned into the denuded bladder and stitched there.

The anterior and posterior peritoneal folds are then drawn down, attached to the vagina, and stitched together in the middle line, two small openings up into the pelvis being left and loosely stuffed with gauze.

#### TREATMENT OF ANURIA DUE TO CANCER OF THE UTERUS.

CHAVANNAZ (*Rev. Mens. de Gyn. Obs. et Ped., de Bordeaux*, Nov., 1899), thinks that the most suitable operation to relieve anuria due to the compression of the ureters by malignant diseases of the uterus, is nephrostomy. He recommends to operate on the larger kidney, or if they are of equal size, upon the right, as its lower situation renders it more accessible. Unilateral nephrostomy is usually sufficient unless the kidney occupied has been almost entirely destroyed. Chavannaz recommends a free lumbar incision, under local or general anæsthesia, unless the patient be comatose.

H. J.

#### CANCER.

KÜSTNER (*Centralb. f. Gyn.*, 1900, No. 14), in "A Palliative Operation for Uterine Carcinoma," proposes colpocleisis rectalis, *i.e.*, making a recto-vaginal fistula, and then closing the vagina; the discharge is led into the rectum and evacuated under voluntary control. The chief advantage of the operation is that the patient is relieved from the abominable stench. The proceeding is a simple one, a broad communication is established between the vagina and the rectum; a pad soaked in alcohol is placed in the vagina, a string attached to the pad passes through the fistula and anus. The vestibulum vagina is closed, and four days later the pad is withdrawn by the anus.

#### CALCIUM CARBIDE IN INOPERABLE CARCINOMA.

GRUDEW, St. Petersburg (*Münch. med. Wchns.*, 1900, No. 24), after long looking for a suitable palliative method of treating inoperable cases of cancer among out-patients, believes he has found it in calcium carbide, first introduced by Guinard in 1896, the effects of which depend upon its decomposition into acetylene and unslaked lime in the body, just as in the bicyclist's lamp. Its action upon the most important symptom of neglected uterine cancer—hæmorrhage—is indubitable; he did not meet with a single case in which the bleeding, however persistent and free it might have been, did not yield to its action, and this

beneficial effect extended also to the other constant and distressing symptoms of advanced carcinoma. As regards pain, the relief was not so constant as Guinard and Livet announced, but in many cases the patients were completely freed from their torturing pain. During the direct action of the carbide upon the new growth, the evil-smelling vaginal discharge generally increased, not infrequently soaking through the tampon, on the removal of which there was a copious flow; but in most cases the discharge soon afterwards diminished in quantity abruptly at the same time losing its peculiar putrid stench. The improvement lasted a week or more, when the symptoms began to return, until another application was necessary. This method of treatment is quite free from danger, and is seldom followed by any unpleasant consequences. One physician known to Guinard met with such a sudden development of acetylene gas that the speculum was blown out of the vagina and the patient became unconscious, and Guinard himself noticed penetration of the gas through the uterus and tubes into the peritoneum, when it caused severe pain. Grusdew did not meet with anything of this kind, and a little prophylaxis in drying the vagina with cotton wool will prevent the too rapid evolution of the gas which, if a way be left for its escape down the vagina, will not find its way into the peritoneum. Guinard met with diarrhœa in two cases, but Grusdew did not see that or any other symptom of calcium carbide intoxication. Almost the only unpleasant accidents were due to the caustic effect of unslaked lime on the vagina and external genitals; accidents easily avoided by protecting the vagina with cotton wool, either dry or soaked in glycerine. For palliative treatment in the out-patient room and sometimes in private practice, calcium carbide is without a rival. Upon in-patients Grusdew recommends the use of calcium carbide as a preliminary, rather than a supplement, to curetting the actual cautery or bromine. In the form of powder he has employed calcium carbide with great advantage in erosions and benign ulceration of the portio.

*Mode of Application.*—In the lithotomy position, after disinfection of the external genitals, the vaginal portion is exposed by a Simons or a Cusco speculum; the vagina and surface of the wound are dried with cotton wool, and with a dry forceps one or two morsels of carbide, the size of a hazel nut, selected of a suitable shape, are applied to the cancerous surface, and at once pressed against it by a sterilised tampon. The tampon consisted of a strip of sterilised gauze and plugs of cotton wool applied so loosely as not to interfere with micturition, and so as to protect the sound parts from the caustic action of the calcium carbide, or rather of the unslaked lime. The patient was usually sent home when the tampon had been inserted, and



returned in a day or two to have it removed, with the dead tissue and bits of lime, and to have the application renewed at once or otherwise as might be necessary.

#### CANCER OF THE OVARY.

At the Berlin Obstetrical Society early this year, GOTTSCHALK exhibited a secondary carcinoma of the ovary due to an adeno-carcinoma of the corpus uteri, which he had satisfactorily removed by total vaginal extirpation.

#### CALCIFIED FIBROMA OF THE LEFT OVARY.

POKROWSKY (*Chirurgia*, February, 1900) reports a case operated on by Professor Djakanow. The tumour was almost spherical, with a diameter of 5 to 6 cm. It was enveloped with a thick capsule of fibrous tissue which passed without any defined limit into the tunica albuginea. The tumour was of stony hardness, could not be cut—a saw was required to divide it. The calcification had proceeded so far that only under the microscope could any parts be found free from lime. Pokrowsky quotes similar cases already published.

#### THE ORIGIN OF UNILOCULAR OVARIAN CYSTS, ESPECIALLY IN RELATION TO THE SO-CALLED HYDROPS FOLLICULI.

v. KAHLDEN (*Ziegler's Beitr. z. Path. Anat.* Bd. xxvii., Heft 1). Contrary to the opinion now almost universally accepted, that in simple ovarian cysts, especially in cases of hydrops folliculi, we have to do with retention cysts of Graefe's follicles, v. Kahlden, on the basis of careful investigations (always of both ovaries) in a series of cases points out that it is rather an adenomatous new growth developing from a sinking in of germinal epithelium. The observation is one of great importance in regard to the histogenesis of papillary and glandular cystoma. The question whether the complex formation of papillary cystoma may be developed from in-sinkings of ciliated epithelium, the author does not consider ripe for discussion. The ova found in such cysts by earlier authors which were the essential basis of the views hitherto prevailing, are also, according to v. Kahlden's investigations, partly the products of degeneration of epithelial cells, partly egg-like forms due to transformatory or new growth processes in the epithelia of the cyst.

#### OVARIAN CYST WITH MULTIPLE MYOMATA.

HOLZ, Berlin (*Centralb. f. Gyn.*, 1900, Nos. 21 and 22), records a case of a III.-para of 41 who sought treatment for severe menorrhagia. Behind the uterus there was a tumour which he took to be a subserous myoma, but which laparotomy proved to be a cyst of the right ovary. This was removed, but as it could



not have been the cause of the bleeding, Holz, by a vaginal hysterectomy, removed the enlarged uterus, in which were a number of interstitial myomata. The patient was very much collapsed and was given subcutaneous salt injections during the operation, but was well in a fortnight. Holz eulogises subcutaneous and rectal injection of salt solution as a prophylactic in gynaecological operations on anæmic patients, the value of which is still far too greatly underestimated.

#### EMBRYOMA OVARII.

STRASSMANN, at the Charité Medical Society, Berlin, on May 10, declared that embryomata only develop from genital cells, and consequently only occur in the testicles and ovaries, and contain tumour elements from all three germinal layers. During the last nine years, thirty-six embryomata have been met with in the Charité Gynaecological Clinic, and these thirty-six represent 11·6 per cent. of all ovarian tumours. They were mostly met with in patients between 21 and 31 years old—myomata occurring later in life—and usually caused severe menorrhagia, and even in their early stages severe pain. Suppuration and torsion of the pedicles of these tumours are dangers especially to be feared during pregnancy; moreover their growth is encouraged by this condition. After discussing the differential diagnosis, Strassman recommended early operation, which can generally be by the vagina, and is indicated even when pregnancy is present. Continued observations proved that the results of operation were nearly always permanent.

#### DERMOID CYSTS OF THE OVARIES.

ARNSPERGER, Heidelberg (*Virchow's Archiv.*, B. clvi., S. 1), on the basis of three cases, confirms Wilms' demonstration as to ovarian dermoids (embryoma Wilms) being formed of all three embryonal layers, and discusses the various theories put forward as to the genesis of these tumours, of which in his opinion parthenogenesis seems most likely to be correct.

EMMANUEL, Charlottenberg (*Zeits. f. Geb. u. Gyn.*, Bd. xlii.), describes a very small ovarian dermoid hardly as big as a pea, which lay in the middle of an ovary in a cyst which he supposed to be an altered Graafian follicle. Microscopically this dermoid contained elements derived from all three germinal layers. This and the fact that it lay in a Graafian follicle, led Emmanuel to conclude that the dermoid (as Wilms asserts to be always the case of ovarian dermoids) originated from an ovum.

DÜHRSEN exhibited at the recent German Surgical Congress, a patient from whom he had removed a dermoid by anterior colpo-cœliotomy. She had, six weeks after the opera-

tion, been able to return to her occupation as an athletic performer.

#### THE REGENERATION OF OVARIAN SUBSTANCE.

W. I. KANEL (*St. Petersburg. med. Wchns.*, 1900, No. 21), from experiments upon rabbits, has arrived at the following conclusion, which he publishes in a preliminary report: The ovaries replace their tissue with surprising rapidity; the wounds heal without granulation tissue and when aseptic, without any cicatrix. The tissue is replaced through the mitotic activity (*karyo-kinesis*) of the segmental epithelial cells constituting the medullary layer of the ovary, which does not culminate till some days after the infliction of the wound. The process is somewhat different in infected wounds in which leucocytes are met with and scar formation takes place.

SOME EXPERIMENTS UPON OVARIAN TRANSPLANTATION IN RABBITS. A Preliminary Report by EMIL KNAUER, Assistant in Chrobak's Clinic, Vienna. *Centralb. f. Gyn.*, 1896, No. 20.

ON OVARIAN TRANSPLANTATION (Labour at normal end of Pregnancy after Transplantation of the Ovaries in Rabbits). By EMIL KNAUER. *Ibid.*, 1898, No. 8.

UPON DR. ARENDT'S "DEMONSTRATION AND REMARKS UPON OVARIAN TRANSPLANTATION," at the 70th Congress of Naturalists and Physicians at Düsseldorf. By EMIL KNAUER. *Ibid.*, 1898, No. 46.

TRANSPLANTATION OF THE OVARIES. An experimental Study, by EMIL KNAUER. *Archiv. f. Gyn.*, Bd. lx., H. 2.

ON TRANSPLANTATION OF THE OVARIES. An Address to the K. K. Gesellschaft der Aerzte, Vienna, by EMIL KNAUER. *Wiener kl. Wchns.*, 1899, No. 49.

CHROBAK was some years ago induced by the effect of the administration of thyroid gland substance to patients deprived of the gland by extirpation, to hope that those who had lost their ovaries might be protected in a similar way from the so-called "cachexia ovaripriva," and suggested to his assistant, Knauer, the possibility of transplantation of ovarian tissue as a subject for research. No investigation of the kind had been made before Knauer commenced early in 1895, two series of experiments upon rabbits. In the one set of twelve he transplanted the ovaries to a distant part of the same animal; in the other set of thirteen experiments, from one animal to another. He proved by these experiments that the ovaries may be transplanted from their normal position to another place, on the

peritoneum or in the muscular tissue; that transplanted ovaries will grow in these new positions, may perform their functions, and produce ovules and even expel them; that ovules so expelled are capable of fecundation, to be followed by normal pregnancy and the delivery of normal young, and that the transplanted ovaries may continue to perform their function at all events for more than three years.

The influence of the ovaries upon the genitals and the mammary glands appeared from the fact that when an animal underwent successful transplantation of both ovaries, the genital organs and mamma continued normal, but when the transplantation failed, exhibited to the naked eye and under the microscope, the typical appearance of *castrations atrophie*. The development of an immature uterus goes on after a successful transplantation, but the influence of the ovaries upon the genitals is intimately connected with ovulation, and does not persist after the ovarian tissue has ceased to produce ovules. The mammary glands of animals in which ovarian transplantation was successful were microscopically entirely normal, but when the ovaries perished were extremely atrophied. It is therefore evident that contrary to the various hypotheses of Hegar, Steinhaus, and Sutugin, Kehrer, Gottschalk, Hoffmeier, Benkiser, Buys, and Vandervelde Sokoloff, it must be the influence of the sexual glands which prevent *castrations-atrophie*, and that any explanations founded on such hypotheses are most improbable.

These experiments have proved that the conservation of the normal sexual gland in any part of the body to which it has been transplanted, is alone necessary to prevent *castrations-atrophie*. As yet we do not know to what the influence of the ovaries is due, nor the way in which it is exercised, but the results of ovarian transplantation justify the assumption that this influence depends on material produced in the ovaries, and entering the circulation by the lymphatics and blood-vessels, and so affecting the organism, that in fact, the ovaries have an "internal secretion."

These experiments also render probable the existence of a trophic correlation between the secondary characteristics of sex (*secundären Geschlechts-characteren*) and the internal secretion of the sexual glands, and the occurrence of normal pregnancy after transplantation is important evidence in regard to the wandering of the ovules from the ovary to the Fallopian tube and of the exact and certain mechanical reception of the ovules.

The second group of experiments, though not so completely successful as the first, prove the possibility of ovarian transplantation from one animal to another. This possibility has also been affirmed by other authors even when the animals have



been of different species, but without the microscopical proofs now given us by Knauer, who, however, has not yet definitely concluded his investigations of transplantation of the ovaries from one animal to another.

In the article in the *Archiv. f. Gynækologie*, Knauer gives detailed accounts of his experiments and methods, and reviews the work done in the same direction by others upon women, *e.g.*—

MORRIS (*N. Y. Med. Jour.*, October, 1895), reported two successful transplantations in women; one, into the tubal stump, followed by pregnancy and abortion of a well-developed foetus; the other from a woman of 30 into the fundus uteri of a girl of 20.

GLASS (*Med. News*, 1899, p. 523) transplanted an ovary from a girl of 17 to the "normal" position in a woman of 29, by the vaginal way.

DUDLEY (*Amsterdam Congress*, 1899), in removing a pyosalpinx duplex from a patient of 24, implanted the right ovary in the fundus uteri and regular menstruation followed, &c., &c. McCONE's article (*v. B. G. J.*, vol. xv., p. 464) he had only seen in an abstract.

#### TORSION OF THE FALLOPIAN TUBES.

HARTMANN (*Comptes Rendus de la Société d'Obstetriques de Paris*, February, 1900), basing his observations on fifteen cases, draws the following conclusions with regard to this rare condition:—

(1) Torsion may affect either the tube alone (seven cases), or both tube and ovary (five cases); the uterus may sometimes share in the torsion to a slight degree.

(2) The right tube is most frequently affected (ten torsions on the right side to four on the left).

(3) On the right side the torsion is usually in the direction of the movements of the hands of a watch; on the left most often in the opposite direction.

(4) The number of turns is variable—from one to four.

(5) The twisted organs present lesions of two kinds: the one anterior to the torsion and due to the causal disease—most frequently hydrosalpinx, more rarely a slight salpingitis, exceptionally a pyosalpinx, or a hæmorrhagic oöphoritis; the others consequent on the torsion, and identical with those usually found in organs with twisted pedicles.

(6) All the vessels of the pedicle may be thrombosed, or some may still be permeable.

(7) Clinically, torsion of the inflamed adnexa may present two forms. In one the onset is sudden and the symptoms violent, resembling those of intestinal obstruction or acute



appendicitis; in these cases there is complete thrombosis of the vessels. In the other form there are successive painful attacks resembling nephritic colic, and the torsion is less marked and comes on more gradually. H. J.

LEGUEU (*Presse. Med.*, January 20, 1900) records three cases of torsion of a cystic tube. In one case, in which the tube was subsequently found to have undergone half a turn, the patient was seized suddenly with severe abdominal pain and vomiting; menstruation, which had started, became very profuse, and her temperature rose to 102° F. All symptoms subsided in a day or two, and on the sixth day from their onset the tube was successfully removed. H. J.

PRAEGER (*Archiv. f. Gyn.*, Bd. lviii., S. 579) collected twenty-two cases, including two of his own. In his opinion, that torsion of the tube does not occur oftener, is due to the pedicle not being long enough to allow of twisting; torsion cannot well happen if there are adhesions, or unless there be some cyst or new growth of the free end of the tube. The commonest condition associated with torsion is simple hydrosalpinx without adhesions. The causes of torsion are the same for the tubes as for the pedicles of ovarian tumours. Strangulation and bleeding into the sac and tube may follow and the blood may escape into the peritoneal cavity. Gangrene, sepsis, and peritonitis may result. The symptoms, course, diagnosis, prognosis, and treatment are practically the same as those of torsion of the pedicle of ovarian tumours.

F. E.

#### THE CONSERVATIVE TREATMENT OF INFLAMMATORY ADNEXAL AFFECTIONS.

HERRMANN, Breslau (*Zeits. f. Geb. u. Gyn.*, Bd. xlii., Heft 2), writes: Investigation of the pus has shown that the cause of inflammation of the adnexa is gonorrhœa in 50 per cent. of the cases, while only 27·6 are due to strepto- and staphylo-cocci. But *quoad vitam* gonorrhœa differs from septic puerperal inflammation in offering an absolutely favourable prognosis, and therefore with regard to it a fanatically radical treatment is unjustifiable. As to the prognosis of tubal affections *quoad reparationem*: (a) Some of these affections may be cured without operation, so that function is preserved. (b) Even when suppuration in the tubes can be demonstrated, recovery with function preserved is quite possible. (c) In adnexal affections that necessitate operation, if sound or but slightly diseased adnexa be left behind on one side they may afterwards function in the normal way.

Although Martin, v. Winckel, and more especially Küstner, advocate conservative principles in affections of the adnexa,

radical measures have of late years been more generally recommended. The evil results of the radical operation and especially of the symptoms of omission and the frequency of a favourable course after expectant treatment lead the author to suggest the following principles for the treatment of suppurating affections of the adnexa. In acute cases employ antiphlogistic measures as long as possible; in chronic cases, operate if the pus has become sterile (which may if necessary be tested by an exploratory puncture), that is to say from nine to twelve months after the last infection. Open the peritoneum by the abdominal (not the vaginal) way; make the operation as conservative as possible. Hermann concludes his article with a review of thirty-four cases of pyosalpinx treated by operation in the Breslau Clinic. No case was fatal; there was indeed no reaction in eighteen cases, but some fever in the others.

#### BILATERAL OPERATIONS ON THE ADNEXA AND THEIR LATE RESULTS.

BARUCH, Berlin (*Zeits. f. Geb. u. Gyn.*, Bd. xlii., Heft 2), reviews in regard to the anatomical conditions, hæmorrhage, omission symptoms and stump-exudations, and also in regard to the restoration of capacity for work, a series of Czempin's operations, seventy cases in fifteen of which the uterus was removed as well as the adnexa. He concludes that the results were more satisfactory, as regards definite cure, when the uterus was removed; when it was extirpated there were not any stump-exudations or hæmorrhages and omission symptoms were less frequent and less severe. On the other hand, as regards capacity for work, the results were much the same and in Baruch's opinion justify the operation of salpingo-öophorectomy in chronic, inflammatory and suppurating affection of the adnexa. Of cases of this kind, half were completely cured, though the uterus was not removed, and the other half were improved. There was no case in which the operation was not beneficial.

#### THE ANATOMY OF THE REFLEXA IN TUBAL PREGNANCY.

COUVELAIRE (*Comptes Rendus de la Société d'Obstétrique, &c.*, de Paris, March, 1900) brought before the Society a paper with the object of proving, by objective demonstration, the existence in the gravid tube, during the early months, of a membrane which, separating the free pole of the ovum from the tubal cavity, performs the function of the reflexa. He showed two specimens—one removed *post mortem*, the other during the course of a laparotomy, and from his examination of them drew the following conclusions:—

(1) During the early months there exists in the pregnant tube a membrane which, separating the free pole of the ovum from the tubal cavity, performs the function of a reflexa.

(2) At the level of this reflexa, chorionic villi and intervillous spaces are found sixty-six days after the last menstruation, similar to those developed at the parietal insertion of the ovum. A little later, at about two-and-a-half months, owing to the obliteration of its vessels, the atrophy of this "placenta reflexa" is almost entirely effected.

(3) The membrane which separates the intervillous space from the tubal cavity is formed of two distinct layers: (a) an internal, continuous, and compact layer—the cellular layer of the reflexa; (b) an external interrupted layer—the fibrinous layer.

(4) The internal cellular layer is continued without any break over that portion of the ovum which is attached to the tubal wall. The external layer does not penetrate into this area.

(5) The cubical epithelium which covers the free section of tube facing the reflexa does not penetrate over the area of parietal attachment of the ovum. It stops short at its edge, or else is reflected for a short distance over the cellular layer of the reflexa.

(6) Sixty-six days after the last menstruation the reflexa was found to have no vessels, and the living decidual cells were continuous with the parietal decidual layer as in the uterus.

(7) The decidual change in the pregnant tube during the first month is far from being as marked or as general, even in the zone which is in immediate relationship with the ovum, as it is in the pregnant uterus of the same age.

H. J.

#### TUBAL PREGNANCY; ITS ETIOLOGY.

MOERICKE, Stuttgart (*Graefe's Samml. Zwangl. Abhandl.*, Bd. iii., Hft. 4), while he admits that pregnancy generally begins outside the uterus, denies Strassmann's statement that it does so invariably. He enumerates, only to set aside, the following alleged causes offered by various authors to explain the occurrence of tubal pregnancy: (1) pelvi-peritonitis; (2) interstitial myoma; (3) diverticles of the tubes and accessory tubes; (4) mutual interference of the ovula in plural conceptions; (5) extra-uterine transit of the ovum to the other tube; (6) reversed peristalsis of the tube; (7) trophic derangements of the tube; (8) infantile forms of the tube; (9) tubal and especially gonorrhœal catarrh. On the basis of ten years' practice in Chili and four in Stuttgart, Moericke considers all such explanations erroneous, and after discussing the embedding of the ovum and shortly describing experiments upon animals bearing upon it, he passes to the question of the formation of decidua in the tube and concludes with Webster and Patellani that the embedding of the ovum is to be referred to dysteleologic or atavistic con-



ditions. After a more detailed examination of the arguments in favour of Patellani's view, he declares that: "The human ovum does not embed itself in the tube unless there be some morphological or functional dysteleology therein," and after comparing the social conditions of life in Germany and Chili he formulates the hypothesis that tubal pregnancy is an atavistic phenomenon, the prevalence of which is due to our unhappy social conditions. The chief value of Moericke's article is that it gives a good review of all that research has up to the present disclosed about the etiology of tubal pregnancy.

**TUBAL PREGNANCY AND ITS EARLY DIAGNOSIS FOR THE PURPOSE OF OPERATIVE INTERVENTION.** By MARTINEZ. Abstracted by ANTONIO D'ALESSANDRO.

*Arch. Ost. Gin.*, April, 1900.

MARTINEZ insists upon the bimanual examination of every suspicious case, and upon operation before fatal hæmorrhage may set in. He believes tubal pregnancy to be much more frequent than would appear from its literature and, contrary to the opinions of Auvard, Ribemont, Pozzi and others, that it is almost always possible to diagnose it during the first stage and very often even at the second month. The numerous cases past the foetal period observed in gynæcological clinics prove that, as a rule, the foetus dies within the first three months, so often in fact before betraying its existence, that nine-tenths of the cases escape detection, and ectopic gestation is said to be rare because it is seldom discovered while the foetus is alive. Hæmatoceles, more or less painless, of medium volume and progressive course, are evidence of tubal pregnancy. The extirpation of foeto-cystic or embryo-cystic tubes in the first three months after conception is a benign operation, while expectant treatment exposes the patient to the many dangers that may arise from the growth or infection of the hæmatocele, and increases the difficulties of operative interference.

F. E.

#### ECTOPIC GESTATION: ITS OPERATIVE TREATMENT.

JUNG, Greifswald (*Centralb. f. Gyn.*, 1900, No. 22), reports two cases of ruptured tubal abortion with hæmatocele, cured by anterior colpotomy—in each case the products of conception were removed by the vagina, and the tube left in a condition to carry out its function. In connection with these cases he attacks the statements of Madlener and Hermann that vaginal operation for tubal gestation is improper when the sac is entire, declaring that serious adhesions are the only contra-indication to its selection. The kind of operation to be chosen depends on whether the case be one of abortion, of rupture with a small



tear or rupture with extensive laceration. In the former case, one should enucleate the ovum and stitch up the slit in the wall of the tube in Martin's way, in the latter the tube should be resected. Martin has long recommended anterior colpotomy for the treatment of tubal pregnancy. Abdominal cœliotomy should be confined to cases of acute anæmia, to those in which the ovum has reached an extreme size, or in which there are excessive adhesions.

MADLENER, Kempten (*Monats. f. Geb. u. Gyn.*, B. xi., S. 757), considers posterior vaginal cœliotomy not to be a suitable method for the removal in its early stages, of an unruptured tubal pregnancy, not even when such a pregnancy has led to the formation of an hæmatocele, though a suppurated or putrefied foetal sac may be dealt with in that way. He reports a remarkable case of a decomposed full term extrauterine pregnancy, in which, under circumstances of extreme difficulty he was able to remove the macerated foetus through the posterior vaginal vault. The placenta remained in the sac, but was discharged in the course of a fortnight through the vaginal wound. The large cavity of the putrefied sac took six weeks to heal up. He relates also a case of the removal of the pregnant tube by anterior colpotomy. On account of the extremely unsatisfactory course of the operation, he thinks this method only to be recommended in unruptured tubal pregnancy in the earliest months, or perhaps for dealing with cases immediately after rupture or abortion.

STUMPEL, Munich (*Deutsches. Archiv. f. kl. Med.*, B. xl., No. 7), reports two cases; in the first, in a very early stage, the foetus being alive, the sac was punctured and nearly half a grain of morphin was injected, after which the woman recovered without any reaction, and the author takes the opportunity of warmly recommending this proceeding. In the second case pregnancy had reached its term. The contents of the first sac in the abdomen had putrefied, but at the operation it proved possible to extract the macerated foetus without opening the peritoneal cavity, and the woman got well.

HOCH, Villach (*Wiener kl. Wchns.*, 1900, No. 23), gives the particulars of the removal by laparotomy, from a woman of 31, of a tumour weighing 4,460 grammes, an extrauterine pregnancy the macerated foetus dating from eleven and a half months before the operation. Hoch points out that while ectopic pregnancy is hardly a rarity (Frommel's report for 1890, giving 135, for 1891, 123 cases). Kleinwächter in 60 cases met with only one carried to term, and Thorn declared that not more than 10 per cent. escape rupture or abortion in the first three months.

The woman, in spite of ileus and fæcal vomiting, which lasted three weeks, recovered.

#### EXTRA-UTERINE PREGNANCY AND PERITONEAL DRAINAGE.

TUFFIER (*Sem. Méd.*, May 16, 1900), in discussing the question of the use of drainage after severe peritoneal hæmorrhage due to ruptured tubal pregnancy, states that he considers Mickulicz's method to be insufficient. When he operates by the abdominal route he uses Delagenière's metallic drains, but for some time he has, wherever possible, opened the vagina and drained through it.

H. J.

#### ON THE PERSISTENCE OF MENSTRUAL HÆMORRHAGE DURING PREGNANCY.

By F. CARUSO. *Archivio di Ost. e Gin.*, 1900, April.

The author discusses the question generally, gives one case and concludes: (1) That periodical hæmorrhages similar to the catamenial losses may occur during pregnancy in intimate relation with the menstrual process; (2) that such hæmorrhages, not infrequent in the early months of pregnancy, may in rarer cases persist to term, and may then, still more rarely, recur in the same form in subsequent pregnancies. (3) That it is not possible, as science stands at present, to give an exact judgment as to the internal cause of the hæmorrhage. Evidently one or more previous pregnancies predispose to such loss. (4) That in the majority of such cases the duration of pregnancy is normal and the fœtus undergoes normal development.

F. E.

#### HYPEREMESIS GRAVIDARUM.

DIRMOSER (*Wiener Med. Wchns.*, 1900, No. 19) attributes the vast majority of serious cases to auto-intoxication from the intestinal canal, to the disinfection of which he directs his treatment. He explains in this way the well-known beneficial effects of creosote preparations and of small doses of calomel in slight cases. Even in cases which were not very severe he has found it best to suspend all nourishment by the mouth and substitute nourishing milky enemata, and copious intestinal irrigation with boric acid or sometimes permanganate of potash, and to wash out the stomach with a solution of boric acid or bicarbonate of soda. When the vomiting has ceased the natural method of feeding is gradually re-adopted. He hopes that by more general adoption of these means artificial abortion—which he has himself induced in two cases successfully—will become quite an exceptional proceeding.

## THE PHYSIOLOGICAL CAUSES OF LABOUR.

THÉNEN, at a meeting of La Société Impériale Royale des Médecins de Vienne (*Semaine Médicale*, April 11), communicated the results of his researches in this direction. He considers that the contact of the impregnated ovum with the maternal organism causes a stimulation which shows itself in the phenomena of pregnancy. The duration of pregnancy depends on the persistence of this irritation, so much so that, when the irritation ceases, the uterus has a natural tendency to return to its normal dimensions. The expulsion of the fœtus is the consequence of this.

The degeneration determined in the placenta at the end of pregnancy is the result of a retrogressive process. At about the thirtieth week of pregnancy the fœtus has reached such a size that blood coming from the fœtal organism contains only a small proportion of nutritive substances. Accordingly, the placenta increases more slowly in size, and about the thirty-sixth week its development ceases. The lack of nutriment results soon in degenerative changes, which start in the villi, and terminate by causing the separation of the fœtus from the mother. The irritation caused by the ovum diminishes at the same time more and more, and, finally, is not sufficient to cause the continuation of pregnancy; the uterus therefore contracts and expels the fœtus.

Thénen considers that this hypothesis has the advantage of explaining the cause of the onset of labour at any period of pregnancy.

H. J.

## ARTIFICIAL INDUCTION OF LABOUR.

GRUSDEW, St. Petersburg (*Centralb. f. Gyn.*, 1900, No. 17), opposes the opinion expressed by Pinard at the Amsterdam Congress, that the induction of premature labour should be entirely abandoned in cases of contracted pelvis and replaced by Cæsarean section, symphyseotomy, or the like. As regards symphyseotomy, the high maternal mortality is the chief argument; in artificially induced labour, though the mortality of the children is greater, the danger to the mother is not more than in physiological childbed. Moreover, it has the supreme advantage that it can be well carried out in private practice. He instances a case of a woman of 45 with simple flat pelvis, in whom he had for the ninth time to induce premature labour. Five children survive in good health. The last time labour began spontaneously at the commencement of the ninth month, but interference was necessary to deliver. He attributes the spontaneous commencement of labour to the acquired habit of the uterus to empty itself in the thirty-fourth to thirty-sixth

week, and offers it as evidence that a habit of abortion may be acquired, contrary to Ahlfeld's opinion. (For fuller Report *v. Obstetrics*, June, p. 287.)

#### ECLAMPSIA.

POPESCU, Czernowitz (*Centralb. f. Gyn.*, 1900, No. 24), describes two cases of puerperal eclampsia which he treated successfully by the administration of a clyster of a tablespoonful of bromidia, a proprietary article said to contain 15 grains respectively of chloral and bromide of potassium and half a grain of extract of cannabis indica and extract of henbane in each drachm. The first patient slept for about sixty hours after the clyster.

MARTIN showed the Greifswald Medical Society (March 10, 1900) a 36-year-old primipara, on whom nine days previously he had performed Cæsarean section at the end of her ninth month. Eclampsia occurred without prodromata. There was orthopnœa and pronounced nephritis. Delivery seemed indicated by the rapid deterioration of her general condition, and was effected by Fritsch's fundal incision. Coma to some extent persisted till the fourth day, but recovery was uninterrupted.

CHARLES, Liège (*Journal d'Accouchements*, April 15, 1900), states that, in spite of all our knowledge and experience, eclampsia still kills nearly a quarter of the women attacked and half the children, and in his opinion an eclamptic woman seven or eight months pregnant is in as great danger as if she had Asiatic cholera. Charles considers that operative treatment—such as Cæsarean section—should not be adopted until fits have occurred. Up to this time medical treatment is sufficient, and then the cervix should be dilated and the foetus extracted.

H. J.

#### PREGNANCY AFTER HYSTERO-COLPO-CLEISIS.

MENGE, Leipsic (*Centralb. f. Gyn.*, 1900, No. 13), records a very interesting case which, save for one published by Lane, would be unique. A woman of 32, three years previously had been operated on by Zweifel for a large vesico-cervical fistula. He first tried to close the fistula from the abdomen, when he tied the right tube (still pervious) with a silk thread. Six days later there was incontinence again, which Zweifel cured by hysterocolpo-cleisis. As the left tube was impervious, the patient was told she would not again be pregnant, but appeared at the clinic three years after the operation in the sixth month of her gestation. As abortion took place during the next month through the ruptured cicatrix of the colpo-cleisis, the proposed Porro operation was unnecessary. After normal childbed the



bladder remained continent. This case again shows that a single ligature does not make the tube impervious to the spermatozoon.

#### COMPLETE RUPTURE OF THE UTERUS. ABDOMINAL PAN-HYSTERECTOMY: RECOVERY.

v. WALLA, Buda Pest (*Centralb. f. Gyn.*, 1900, No. 19), met with a case of rupture in a VIII.-para of 37, due to a neglected crossbirth. The foetus and placenta had been already extracted. The tear was in the anterior wall and extended deeply into the left parametrium. On account of threatened infection v. Walla performed the radical operation, making the vaginal stump extraperitoneal and draining the parametrium downwards with iodoform gauze. The woman recovered in four weeks.

In the Buda Pest Frauenklinik there have been 28 cases of rupture of the uterus; 17 incomplete and 11 complete. The incomplete cases were treated conservatively and 10 died. Of the 11 complete cases 7 were treated conservatively and 6 died, 5 were operated on and 2 recovered. v. Walla concludes that complete rupture of the uterus always indicates operation.

#### RUPTURE OF THE UTERUS.

HAMMERSCHLAG, Königsberg (*Centralb. f. Gyn.*, 1900, No. 24), describes a case of neglected shoulder presentation. Rupture of the uterus occurred six hours after the waters broke, merely in consequence of excessive tension of the greatly elongated and thinned out cervix. There was not any indication of a lower segment as part of the corpus uteri. The case is evidence that the cervix may really rupture from being drawn out and over stretched.

SCHWARTZ, Fünfkirchen (*Centralb. f. Gyn.*, 1900, No. 25), relates a case in which after rupture of the uterus in attempting to turn a neglected cross-birth, the patient drove half an hour in a carriage, one hour by rail, and finally reached the hospital by half an hour's journey on foot. Total extirpation was performed and the dead decomposed foetus removed. Putrid endo- and perimetritis was already established, and in spite of repeated injections of Marmorek's serum, the woman died on the third day after the laparotomy. Diffuse septic peritonitis was found at the autopsy.

#### FORCEPS.

BOKELMANN communicated to the Berlin Society of Obstetrics and Gynæcology, January 26, 1900, the results of 307 cases of forceps' delivery from his private practice. In 154 cases the head was in the outer strait, in 110 in mid pelvis, and in 43 above the brim. Of the 305 mothers 3 only died, and all were

cases of eclampsia; there was no single instance of serious laceration of the vagina or cervix; two complete ruptures of the perineum were the only grave injuries to the mothers. Thirteen of the 307 children were born dead, but the death was in no instance to be attributed definitely to the forceps. Bokelmann claimed a wider field for the forceps in the hands of a skilled obstetrician.

#### CLEIDOTOMY (DIVISION OF THE CLAVICLE) IN DIFFICULT LABOUR.

BONNAIRE (*Presse Médicale*, March 14, 1900) records two cases in which cleidotomy was performed on a dead foetus with the object of facilitating the extraction of impacted shoulders. In one case both clavicles had to be divided, in the other division of one was sufficient. From experiments on five dead foetuses after birth, he states that division of both clavicles reduces the bisacromial diameter by from 9 to 10 cms. The operation is indicated in the case of a dead foetus, when the size of the shoulders, or the smallness of the pelvis, prevents the extraction of the body. It is most usually supplemental to craniotomy. The operation is performed by means of a pair of strong scissors, or with a perforator (cleidotripsy). Bonnaire considers that cleidotomy may be permissible in the case of a living child, when the head has been born but the shoulders will not follow. In none of his experimental cases has the subclavian artery or the subclavian muscle been injured.

H. J.

#### POST-MORTEM DELIVERY.

KIRCH, Krefeld. *Centralb. f. Gyn.*, 1900, No. 25.

A VII.-para, with mitral insufficiency uncompensated, died from pulmonary œdema after giving birth to a living child. Kirch arrived nineteen minutes after the death and found the foot of a second child at the vulva. He succeeded in extracting and resuscitating the second child, but it died a few hours later.

#### THE USE OF THE EXTERNAL TAMPON IN HÆMORRHAGE DUE TO INERTIA OF THE UTERUS.

MULLER (*Sém. Med.*, April 19, 1900) describes the treatment of *post-partum* uterine hæmorrhage due to inertia by means of the compression of the abdomen *en bloc*, or external tamponning. To perform it, he rolls a bed-sheet round the abdomen of the patient, as high as the umbilicus, and fastens the ends of the sheet together. The space left between this bandage and the abdominal wall is then plugged as tightly as possible with napkins, handkerchiefs, or anything of that kind which is handy. When the bandage is firmly applied, the uterus will be found to be crowded down behind the symphysis, and hæmorrhage is

usually checked at once. Even if the hæmorrhage is not completely checked, it will be diminished in amount, and so time will be given to permit of carrying out the necessary internal treatment in an aseptic manner.\*

H. J.

#### METRITIS DISSECANS PUERPERALIS.

BECKMANN, St. Petersburg (*Zeits. f. Geb. u. Gyn.*, Bd. xlii., Heft. 3), on the basis of fifteen personal observations of the rare puerperal affection to which the above name is given, and forty published cases, has formulated the typical description here set forth of the disease, which he prefers to designate as "puerperal gangrene of the uterus." Briefly speaking, it consists in a tissue necrosis affecting the uterine wall and due to streptococcic infection, delimited as a rule by secondary suppuration in the fourth week, and afterwards cast out as a sequestrum. Recovery is then the usual course. The diagnosis may be made before the sequestrum is discharged and very often from the local condition alone, but there is also high fever, delayed involution of the uterus, swelling of the walls of its cavity, and extremely putrid and bad coloured lochia. The mortality hitherto has been 27·5 per cent. Causal factors are to be found in operative interference (in 52 per cent. of all cases), protracted labour and enteric fever. In those parts of the uterine wall which escaped necrosis, Beckmann detected a peculiar degeneration in the way of vacuolisation of the muscular tissue. Expectative treatment is indicated; intrauterine injections are to be particularly avoided on account of the danger of perforation.

GOTTSCHALK recently reported a case of this kind to the Berlin Medical Society. Version had been performed in spite of imminent rupture and was followed by typical puerperal fever; on the fourth day the uterus was washed out with 2 litres of 1 per cent. lysol solution and 1·5 litre of 60 per cent. alcohol; on the sixth day the patient had a camphor injection every hour, and in the evening 0·75 litre salt solution subcutaneously. Her condition immediately improved, perspiration was established, the quantity of urine, which had been much diminished, increased to 3,000 grammes within twenty-four hours. The lochia stank on the fifteenth day, and on the eighteenth a mass of tissue was expelled, in form like the uterus, and really a necrotic portion of its wall and permeated by streptococci. The woman recovered. Gottschalk attributed this sloughing of the uterine wall to deficient blood supply (the

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\* [An old plan was the insertion, under a tight binder, of the large pincushion generally provided for the confinement, after removing the pins, and supplementing it with napkins.—ED.]



pulse could hardly be felt for twenty-four hours), probably caused by large doses of ergot, the ice bag on the hypogastrium and the wide spread occlusion of veins and lymphatics; the irrigation with alcohol may have had something to do with the necrosis also.

THE SURGICAL TREATMENT OF ACUTE PUERPERAL SEPSIS,  
WITH SPECIAL REFERENCE TO HYSTERECTOMY.

By HIRAM N. VINEBERG.

*Amer. Jour. Med. Sciences*, February, 1900.

The author begins by disproving the very prevalent opinion that all fatal cases of acute puerperal sepsis terminate within a very short period (five to ten days). He quotes many well known authorities giving 38 cases lasting from eleven to fifty-five days, with an average duration of twenty-three. Among these are 10 cases of septic peritonitis (the most fatal form) in which death was postponed to a date varying from the eleventh to the twenty-eighth day.

The idea, therefore, that surgical intervention in acute puerperal sepsis either does no good or only hastens death, cannot be grounded on the argument that all fatal cases are fatal early. Nor can it be said, if the fatal cases are carefully studied, that because a patient has lived over ten days she will recover without any operation, if she is going to recover at all.

Another great fallacy is the belief that because a patient has become infected constitutionally it is no good doing anything. This is founded on the misconception that the blood and tissues when once infected, are merely feeding grounds for bacteria. As a matter of fact, they destroy the bacteria very rapidly, and unless the latter are reinforced and constantly renewed, the infection is soon destroyed. Even when cultivated germs are introduced into the blood system directly, unless they are in quantities such as to kill the animal immediately, they are quickly destroyed by the tissues.

Many surgeons have been afraid to curette lest they should break through Bumm's granulation zone. This zone only exists in simple cases, and is not present in cases of general sepsis, so that if we have regard only for this zone we ought to act oppositely to the present practise and curette in cases of general sepsis and not in cases of septic intoxication localised in the uterus. There is a growing feeling that too little has been done surgically in puerperal cases and one case of the author's where a gangrenous tube and ovary are found, shows how localised and distinct the lesion may be. He believes in operating abdominally so as to gain a clear view of the adnexa, and advises drainage from above and below, and formulates the following opinions:—



(1) Puerperal sepsis is wound fever or wound infection; wound infection in the female genital canal, as elsewhere, calls for surgical measures such as free drainage, irrigation, and the removal with a sharp instrument of any *débris* or exudate that may form on the surface of the wound. These means failing to accomplish the desired result, ablation of the diseased organ or organs is indicated as a *dernier ressort*.

(2) In a given case of puerperal sepsis a thorough examination of the whole of the genital canal is to be made, in order to determine the site of the original infection.

(3) If this be situated in the uterus, curettage, drainage and irrigations are to be employed. In 95 per cent. of the cases of puerperal sepsis nowadays met with, this plan of procedure will be sufficient to effect a cure.

(4) In the remaining 5 per cent. it will fail, and the symptoms will persist. An exploratory laparotomy is then indicated, the further course to be guided by the lesions found. Generally, total hysterectomy will be necessary. Pus collections should be attacked in the way best for each case.\*

F. E.

#### PLACENTAL TUMOURS.

V. DER. FELTZ, Arnheim (*Monats. f. Geb. u. Gyn.*, Bd. xi., S. 779), relates two cases from Veit's Clinic in Leyden, and adds three other published ones to the thirty-five lately collected by v. Albert. In his opinion many of the cases described as tumours must be looked upon as merely local alteration of placental tissue. Investigation of the two tumours, reported by himself, supports this view. According to the author, so-called angioma, fibroma, myoma, &c., of the placenta is generally a local bulging due to congestion, a hyperplasia either of the umbilical cord, or on one of the larger villous trunks. The coagulation necrosis commonly met with is invariably secondary.

#### FÆTOGRAPHY.

BOUCHACOURT (*L'Obstétrique*, March, 1900) discusses various attempts that have been made to obtain a practically useful skiagraph of the foetus *in utero*, which so far have resulted in comparative failure. This has been due to resistance by the liquor amnii to the passage of the rays; to the movements of both the mother and the foetus; to the dark shadow thrown by the pelvi-vertebral skeleton of the mother; and to the difficulty of getting the sensitive plate equi-distant from the different parts of the uterus. So far it has been only possible to determine the

\* Cf. Prochownick's paper discussed at Hamburg Med. Soc., BRIT. GYN. JOUR., vol. xv., p. 328, and *Brit. Med. Jour.*, Ep., 1900, p. 335 and 439.

presence of the foetal head in the pelvic cavity and of parts of the foetal skeleton in the abdomen in thin subjects.

H. J.

#### HETERADELPHOUS MONSTER.

LANNELONGUE (*Sem. Méd.*, May 16, 1900) showed to the Académie de Médecine de Paris, a young Indian, aged 8 years, and well developed, to whose epigastric region was attached by its upper end another body without a head and formed by a trunk and four extremities, incompletely developed. The palpation of the parts enabled the presence of a certain number of vertebræ to be determined, also the iliac bones and the rudiments of the skeleton of the limbs. Between the upper limbs and the pelvic bones there were some soft parts, beneath which no loops of intestine could be felt. The two subjects were of the male sex, and both urinated at the same moment.

H. J.

- (1) FIFTY FALSE MARRIAGES BETWEEN INDIVIDUALS OF THE SAME GENDER, WITH SOME DIVORCES FOR "ERREUR DE SEXE." *Centralb. f. Gyn.*, 1900, No. 18.
- (2) A NEW SERIES OF TWENTY-NINE OBSERVATIONS OF "ERREUR DE SEXE." *Rev. de Gyn. et de Chir. Abd.*, 1900, February.
- (3) NINETEEN CASES OF COINCIDENCE OF INNOCENT OR MALIGN NEW GROWTHS CHIEFLY OF THE GENITAL ORGANS, WITH PSEUDO-HERMAPHRODISM. *Centralb. f. Gyn.*, 1900, No. 18.
- (4) SEVENTEEN CASES OF COINCIDENCE OF ANOMALOUS MENTAL CONDITIONS WITH PSEUDO-HERMAPHRODISM. By FR. NEUGEBAUER.

Reprints of the above have reached us through the courtesy of the author, the distinguished President of the Gynæcological Clinic of the Evangelical Hospital at Warsaw. The first paper has been already noticed in this Journal (vol. xv., p. 315). The second, which contains twenty-six figures, contains three additional cases of marriage contracted between persons of the same sex, eleven cases of such marriages proposed but not celebrated, and fifteen instances in which public prostitutes were found to be of the male sex. As in the first fifty cases, the great majority of these twenty-nine beyond doubt were instances of penoscrotal hypospadias, and in several this was proved by microscopic examination of the testicles removed before or after death. Such an examination is sometimes the only way to determine the sex of the individual—a point that may be of great forensic importance—and for many reasons where there remains any doubt as to the sex of an infant, it seems better that it should be brought up as a boy.

From his enormous collection of 720 observations of pseudo-

hermaphroditism, the author has selected 19 instances in which this condition was associated with innocent or malign new growths, generally of the genital glands. Affecting the ovaries in five cases, the testes in six, and the uterus in four. There was also one tumour of the cæcum, one of the bladder, one of the inguinal region, and one abdominal tumour, the origin of which was not discovered. As to whether there is any causal-nexus between the hermaphroditic condition, and such tumours, he leaves it to physiologists and pathological anatomists to decide.

In connection with psychical disturbances coincident with pseudo-hermaphroditism that Neugebauer should be able to point to seventeen instances of mental disease among his 713 observations, it is worthy, however, of note that apart from his own experience of one suicide directly due to the anomalous social position caused by *erreur de sexe*, and another case in which he anticipated it from the patient's profound melancholia, he points out three other cases recorded in literature in which the unhappy subjects destroyed themselves; in one instance the autopsy proved that the suicide, who had declared he felt as a man, was a male pseudo-hermaphrodite, and not, as the medical attendant had repeatedly insisted, a female.

TAUBER, of Warsaw, recently reopened the question of the existence of true hermaphroditism in connection with the case of an individual said to possess all the characteristics of a female, though the clitoris was long, a well developed testicle was present in each labium, and the voice was masculine. Clitoris and testicles were removed as the person wished to get married. TAUBER quotes several cases of true hermaphroditism investigated by Billoth, Hepner, and Rauchfuss.

#### INTRAUTERINE RESPIRATION.

BUFNOIR AND DEMAY (*Société Obstétricale de Paris*, 1900), relate a case of intrauterine respiration which is of considerable medico-legal interest. A patient was brought into hospital, shortly after the birth of one living foetus, with the shoulder of a dead foetus presenting. Death had resulted from detachment of the placenta, and embryotomy was performed before the foetus could be delivered. The autopsy revealed the fact that there was some air in the right lung of the second foetus—though not sufficient to float it, while the left was well aerated and floated.

H. J.

#### THERAPEUTICAL FŒTICIDE.

By PINARD, *Jour. des Sciences, Med. de Lille*, May 19 to June 19, 1900.

The professor postulates a case of a woman with a contracted pelvis, in labour, who cannot be delivered spontaneously,

the child being at full term and alive. The intervention which the medical attendant considers indicated as necessary and indispensable is objected to, whether by the patient herself or someone else interested. Another intervention is demanded which involves the death of the child.

The professor discusses successively the question of the right of life and death over the child in such a case as resting in the mother, the father, &c., and concludes by denying such a right, adding that such a right, if it existed, could only devolve upon the physician. This he also denies, for the following reasons:—

(1) The physician should never kill. When a physician deliberately kills, he then ceases to be a physician.

(2) No accoucheur can affirm that, in sacrificing the child, he will save the mother.

He supports the above statements with the following statistics. In his service, embryotomy has been performed 81 times since 1892, exclusively upon dead children. Results: 72 women recovered, 9 died. Mortality: 11·5 per cent.

Paul Bar give the following table of the mortality after Cæsarean section—

Authors			Cases	Women died	Proportion	Children died	Proportion
Leopold	...	...	76	7	9·21, p. 100	5	6·58, p. 100
Reynolds	...	...	22	0	0	0	0
Pasquali	...	...	9	1	11·11	?	?
Olshausen	...	...	29	2	6·89	3	10·34
Zweifel	...	...	14	0	0	1	7·14
Charles	...	...	10	0	0	0	0
Bar	...	...	10	1	10	0	0

General result: in 170 operations 159 women recovered, and out of 161 cases of children known 152 were born alive, equal to a mortality of 6·41 per cent. for the mothers and 5·59 per cent. for the children.

Moreover, out of 100 symphyseotomies performed by Prof. Pinard 88 women recovered and 12 died.

The professor sums up his lecture by saying that the accoucheur has no right, whether morally, legally, or scientifically, to perform embryotomy upon a living child.

To believe that to sacrifice the child is to save the mother, is a legend which must disappear.

The right of life and death over the child belongs to no one, neither the father, the mother, the physician, nor even to the director of the hospital. The right to decide upon the operation belongs only to the physician.

P. Z. H.



## NOTES

DR. SERAPHINO PATELLANI, privat-docent in the Faculty of Medicine at Parma, has been nominated privat-docent of Obstetrics and Gynæcology at Bologna.

DR. F. S. CULLEN and Dr. W. W. RUSSELL have been appointed Professors of Gynæcology in the Johns Hopkins University at Baltimore.

V. OTT, St. Petersburg, publishes in the *Monats. f. Geb. u. Gyn.* a detailed description with plans of a huge institute for midwifery and the diseases of women about to be erected under his direction, in the hope of encouraging criticism and enabling a larger circle of specialists to assist in the establishment of this pattern institute.

PROFESSOR PORRO, we are glad to know, has completely recovered from the serious indisposition which at one time threatened to deprive Italy of one of her most distinguished senators.

GEORGES APOSTOLI, M.D., of Paris, whose name is associated with the electric treatment of uterine fibroids, died on April 27 of influenzal pneumonia. He was the son of a medical practitioner, and was born at Saint-Michel-de-Lanès in the Aude Department in 1847. He was admitted to the School of Military Medicine at Strassburg, where he was a pupil of the well-known surgeon Sédillot. After ten years' service in the army, spent mostly in Algeria, he resigned his commission and proceeded to Paris, where he worked under Tripiier. From that time he gave himself wholly to the medical applications of electricity. Through the mouth of his pupil Carlet, whose thesis, presented in 1884, is a landmark in the history of gynæcological electricity, Apostoli made known the results which he had obtained in the treatment of uterine fibroids by the method now generally known by his name. He continued to report his further results, and the modifications in procedure suggested by larger experience, in communications to various congresses in Europe and in America. He was present

more than once at the annual meeting of the British Medical Association.

Apostoli was an earnest worker in the field of practice which he chose for himself. As to the value of his work opinions differ, and we do not feel called upon to attempt to offer a definitive judgment. But a method which gained the adhesion of such a man as Thomas Keith cannot be lightly put aside. Nor would it be just to withhold all expression of admiration for a man who, like Apostoli, in the face of much opposition and without the help of academic position, without even the prestige that is given by a hospital appointment, made his name known throughout the medical world.—*B. M. J.*

THE Royal Academy of Medicine of Belgium offers among others a prize of 800 francs for the study of the pathogenesis of eclampsia. The competition closes on May 15, 1901. The essays must be written in Latin, French or Flemish, and must not have been previously published completely or partially, or presented to other scientific bodies. The Secretary of the Academy is E. Masoni, Bruxelles.

THE French Academy of Medicine offers twenty-four prizes for competition not confined to French physicians, among others the Prix Capuron, 1,000 francs—Subject: on Rigidity of the cervix uteri during accouchement, excluding that caused by cancer and fibroma; the Prix Chevillon, 1,500 francs, for the best work on the treatment of cancerous affections; and the Prix Jacquemier, 1,700 francs, for the work effecting the most important progress in some obstetrical subject. The Prix Adrien Buisson, 10,500 francs, will be awarded to the author of the best discoveries resulting in the cure of diseases recognised up to date as incurable. Essays in French or Latin to be sent to the French Academy of Medicine before the end of February, 1901.—*Phila. Med. Jour.*, June 16, 1900.

THE Academy of Medicine has accepted the bequest of the lamented Professor Tarnier. Of the income of this legacy, which will be some 5,000 francs per annum, 3,000 francs are to be given annually for the best work either written or printed on obstetrics or gynaecology.

THE Faculty of Medicine of Paris is particularly anxious that two new chairs for gynaecology and infantile surgery should be created. The Paris Municipal Council has undertaken to provide the cost of the chairs and of the necessary clinical material.

## SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

*Opinions as to pathology or treatment expressed in the following abstracts are not necessarily endorsed by the editors or their collaborators. Any Fellows of the Society who may be willing to give the editor-in-chief regular assistance in the preparation of this summary are requested to communicate with him. He will be greatly obliged by having his attention drawn to any important work published at home or abroad; particularly so by receiving condensed abstracts of such work from the authors themselves.*

### THIRTEENTH INTERNATIONAL CONGRESS OF MEDICAL SCIENCES.

Paris, August, 1900.

#### SECTION OF OBSTETRICS AND GYNÆCOLOGY.

ABSTRACTED BY HENRY JELLETT, M.D., from the official

*Résumés des Rapports, and the Semaine Médicale.*

#### ÆTIOLOGY OF PUERPERAL INFECTION.

Dolérís classified the microbic causes of puerperal infection under two heads:—(1) Aerobic bacteria—the *Streptococcus aureus*, the *Gonococcus*, and the *B. coli*; and (2) Anaerobic bacteria, including the ordinary septic and the putrid bacilli, and others less known. Certain kinds of saphrophytes also may in some instances become pathogenic. Various kinds are frequently associated in a single case. The question of auto- or hetero-infection is still unsettled, but Dolérís is inclined to admit that, in certain cases, pathogenic microbes, pre-existing in the genital cavities, may undergo a revivescence after confinement, and cause infection, without the assistance of pathogenic microbes from without.

MENGE AND KRÖNIG held the pathogenic bacteria capable of producing puerperal fever to be the *Streptococcus pyogenes*, *Staphylococcus aureus*, *Gonococcus*, *B. coli*, *B. diphtheriæ*, the diplococcus of pneumonia and certain anærobic germs. With certain reservations the authors are not partisans of auto-infection, while they consider heterogeneous infection to be of the greatest importance, its source being probably, not in the air, but

in the hands of the obstetrician. Apart from general predisposing causes, local ones may be found in insufficient hæmostasis and lesions of the genital tract. Extension, and generalisation of the infection, usually occur when the endometrium or the placental surface is infected, the dissemination of microbes taking place through the lymph and blood vessels.

PESTALOZZA, as a result of his experience at Florence, expressed his conclusions as follows:—The aseptic course of the puerperium depends upon the careful disinfection of the external genitals of the patient, and of the hands and instruments of the accoucheur. Disinfection of the vagina of a healthy patient must be condemned as useless and dangerous. It is best to refrain from vaginal examination and manipulations in patients with infectious diseases of the genital organs. Disinfection of the vulva, and of the hands of the accoucheur, is sufficient to prevent all possibility of infection during the confinement. Puerperal fever may, however, occur owing to intoxication (sapræmia); and antiseptic assistance, to be properly carried out, ought also to include the necessary precautions against putrid intoxication, *i.e.*, the prevention of premature rupture of the membranes, the immediate suture of all vaginal wounds, and the prudent management of the third stage. No vaginal and intra-uterine injections should be used during the puerperium.

It is of the greatest importance when infection occurs to recognise its points of entrance, *i.e.*, vulvar, vaginal, cervical, uterine, or combined. The practice of immediately resorting to intra-uterine injections in all cases is wrong. Bacterial researches confirm the frequency of infection by the streptococcus. It was the only organism which Pestalozza was able to detect in puerperal peritonitis or metastatic abscesses, while staphylococcal infection occurred only under the form of multiple small abscesses in the uterine wall, and the *B. coli communis* was met with only in intra-partum fever due to decomposition of the liquor amnii.

VEIT said that auto-infection is almost impossible, as the genital mucous membranes can defend themselves against the attacks of microbes *in situ*.

HOFMEIER remarked that, as the saphrophytes of the vagina may become hurtful, preliminary disinfection of the vagina is not a useless proceeding.

#### SURGICAL TREATMENT OF CANCER OF THE UTERUS.

DMITRI DE OTT (S. Petersburg) in introducing this subject laid down the following rules:—Surgical treatment ought to be adopted in all cases; it constitutes the best means of relieving the patient, and often gives a permanent cure not expected beforehand. Operation by the abdominal route is very dangerous.



It permits the extirpation of the ganglia, but it rests on theoretical grounds which are not justified by clinical facts and its indications are not accurately determined. The route of choice is the vaginal, which, thanks to morcellation, renders possible the removal of even very extensive tumours. In pregnant patients, vaginal hysterectomy can be performed up to the seventh month, after the uterus has been emptied by the vaginal Cæsarean operation. When pregnancy is more advanced, abdominal hysterectomy is preferable, in the interests of the child. In his own clinic there has been in 189 cases a mortality of 1.6 per cent. The after results of these cases are interesting: 62 patients were operated upon more than six years ago; of these 47 had cancer of the cervix, and 15 cancer of the body. Of the 47, 11 are alive without any return of the disease; of the 15, 7 are similarly situated. Of the remaining 44, some are dead, others have been lost sight of. From these results it appears that cancer of the cervix is much more severe than is cancer of the body. Dmitri de Ott uses ligatures exclusively, and does not close the opening in the vaginal vault, but plugs it with iodoform gauze to allow drainage. Two per cent. of his cases had secondary, but not fatal, hæmorrhage.

CULLEN (of Baltimore) considered the combined abdomino-vaginal operation of Werder, of Pittsburg, to be the method of choice. Its principal advantage is its freedom from any danger of grafting the cancer on adjacent parts. The method entails two preliminary stages, in which all projecting cancerous masses are removed (several days before the operation), and the ureters catheterised, and two subsequent stages in which the uterus is removed. The former of the two subsequent stages consists in the following steps:—Ventral cœliotomy, ligation of the round and utero-ovarian ligaments, opening of the broad ligaments, liberation of the bladder, dissection out and freeing of the ureters, ligation of the uterine arteries, freeing of the vagina before and behind, removal of the ganglia, suture of the anterior peritoneum—drawn backwards with the bladder—to the posterior peritoneum (whilst the uterus is drawn strongly downwards by means of a vaginal forceps placed on the cervix), and then closure of the abdomen. The second stage, performed at the same sitting as the first, consists in the division of the ring of vaginal tissue which surrounds the cervix by the thermo-cautery, the extirpation *en bloc* of the uterus by the vagina, and the plugging of the vagina with iodoform gauze. Out of 176 cases seen at Johns Hopkins Hospital, 103 were operated upon—61 cases of flat-celled carcinoma of the cervix with 13 cures, 12 cases of adenocarcinoma of the cervix with 2 cures, and 30 cases of adenocarcinoma of the body with 19 cures. From these statistics

it would seem that cancer of the body is three times less dangerous than is cancer of the cervix. Cullen found the lymphatic ganglia infected by the cancer in only four out of 89 cases.

RICHELOT, after discussing exhaustively the relative merits of the abdominal and vaginal operation, and of the value of the removal of the ganglia, came to the conclusion that the effect of vaginal hysterectomy, done with the object of preventing the invasion of the other tissues, is a cure which appears permanent, or a prolongation of life without permanent cure. Abdominal hysterectomy is only suited for special cases; it is an imprudence in cases of cancer which have invaded other tissues, and an illusion in cases of limited cancer.

BOUILLY stated that he operates by the vagina, and closes the vault subsequently to the removal of the uterus. He divided his cases into two periods. In the first, from 1886 to 1896, he operated on 127 cases with a mortality of 19 per cent.; in the second period, from 1897 to 1900, he operated on 56 patients, with a mortality of 5.35 per cent. His after results are as follows:—Out of the entire number of 183 cases, 28 patients who died after the operation, and 21 of whom he has lost sight, may be eliminated. Of the remaining 134, 18 are still living, of whom two have had a recurrence. Of the remaining 16, 5 were operated on during the present year.

#### ECLAMPSIA WITHOUT ALBUMINURIA.

BOUFFE DE SAINT-BLAISE recorded three cases of eclampsia in which albuminuria was wanting, both before and after the eclamptic fits. In the first case there were no premonitory signs. During the two days which followed the attacks slight transitory traces of albumen were to be found. The case terminated fatally. The two other patients, who had histories of previous hepatic trouble, presented the general symptoms of poisoning; their urine contained abundant evidence of biliary waste, but no albumen.

BAR stated that there was no doubt but that in eclampsia the principal lesions are in the liver, while the urinary excretion sometimes remains unmodified either in quantity or quality. Out of 70 cases he has met with 7 in whom there was no albumen before or during the eclamptic seizure, but he was, however, always able to demonstrate its presence after the attack. There are many varieties of albumen; in addition to the peptones there is a special form of albumen—"acéto-soluble," which it is convenient to place between the peptones and the true albumens—and the albuminuria determined by this form passes unperceived. Whatever rôle the liver plays in the production of the attacks, it is evident that the troubles of the

kidneys are secondary, and that the fact that they are functioning well affords no protection from fatal eclampsia.

#### THE TREATMENT OF ECLAMPSIA.

PORAK said that, in the treatment of eclampsia from 1882 to 1891 he employed bleeding, accompanied by the administration of morphine and chloral, and out of 50 cases so treated he had 14 deaths. From 1891 to 1898 he used injections of a 7 per cent. saline solution only, with the object of producing diuresis. This proceeding gave better results, inasmuch as 12 out of 41 died. For the last year and a-half, acting on the supposition that the eclamptic crisis is the symptom of an intoxication of gastrointestinal origin, and that it is often provoked by peripheral stimulation, he has adopted a treatment consisting of copious lavage of the intestine (30 to 50 litres of fluid) and of the blood (bleeding up to 750 grammes, followed by the injection of a litre and a-half of saline solution), and endeavours to prevent the production of eclamptic reflexes, particularly by introducing no fluid into the stomach during the entire duration of the attacks: moreover, he terminates the pregnancy as rapidly as possible by forcibly dilating the cervical canal. Out of 47 cases so treated only 3 died.

STROGANOFF, who considers eclampsia to be an infectious disease whose mean duration does not exceed forty-eight hours, administers narcotics (morphia combined with chloral) after the first convulsive seizure, for twelve to twenty-four hours, according to the gravity of the case. He also assists the action of the lungs (by changing the position of the patient, oxygen inhalations, &c.) and of the heart (by the introduction of artificial serum into the rectum or mouth). He accelerates labour when any danger appears for the mother or child.

MANGIAGALLI (Pavia) considers that operative treatment, combined with the internal administration of *Veratrum Viride*, gives the best results. Out of 18 patients so treated he had only 1 death.

LA TORRE (Rome) said that he was opposed to obstetrical interference, as medical treatment usually succeeds. He endeavours to assist the action of the skin, and administers morphia (up to 0.1 grm. in twenty-four hours).

#### THE TREATMENT OF UTERINE DISPLACEMENT.

TERRIER (Paris) states that in his opinion, for the operative treatment of prolapse, ventral hysteropexy, with subsequent colpo-perineorrhaphy, was the most suitable procedure, as it permits the examination and treatment of the adnexa.

FOURNIER (Amiens) said that he had entirely abandoned the

use of pessaries and usually performed vaginal hysteropexy, if the case was not complicated by the presence of a high-situated inflammation of the tubes; if it was so, he preferred ventral hysteropexy.

STANKEWICS (Lodz) also considered pessaries to be inadmissible. Abdominal hysteropexy he thought to be too dangerous; and in young women, vaginal hysteropexy also. In the case of women near the menopause he adopts the latter, but for other cases prefers either Alexander's operation or the intra-peritoneal shortening of the round ligaments. He has performed Alexander's operation twice with two failures; intra-peritoneal shortening by the vaginal route 27 times, with but one immediate failure, and one relapse after a subsequent pregnancy.

SCHWARTZ also preferred intra-peritoneal shortening of the round ligaments, but he performs it by the abdominal route.

#### CHRONIC INVERSION OF THE UTERUS; ITS CONSERVATIVE TREATMENT.

SPINELLI (Naples) described a new operation for the reduction of a chronic inversion of the uterus. After disinfecting the vagina, he seizes the inverted uterus and draws it down as far as it will come. He then makes a vertical incision through the anterior face of the cervix and body of the uterus, and opens the anterior *cul de sac* by a transverse incision which crosses the uterine incision. He thus obtains two lateral flaps, which, when turned back, provide a large opening, through which he is enabled to seize and reduce the fundus by traction combined with pressure from below upwards. When the inversion has been reduced, he sutures the incision in the uterus, replaces the organ in the abdomen, and closes the opening in the anterior fornix. He finds the operation inoffensive, conservative, and efficacious, and moreover one which does not leave the patient with the retro-deviation which so frequently results after posterior colpo-hysterotomy.

#### TREATMENT OF APPARENT DEATH OF THE NEW-BORN.

SCHULTZE (Jena), in a communication on this subject, stated that the asphyxia, which characterises the apparent death of the new-born, is due to the fact that the respiratory medullary reflex is lost. If the reflex is only temporarily in abeyance, the medulla can still react to certain stimuli such as cold; but the medulla may become quite insensible to stimuli, and in this case nothing but the supply of oxygenated blood to the medullary circulation will re-establish the reflex power. Working on these principles, he proceeds as follows:—

If the infant is of a red-blue colour and if there is still some



tension in the muscles, he does not cut the umbilical cord so long as he can perceive pulsations, but clears all mucus out of the mouth and stimulates the cutaneous reflexes. If, after a little the infant does not revive, he cuts the cord, plunges the child for a very brief moment into a cold bath, and then into a hot one. These immersions are repeated until the child cries.

If, however, the infant is pale, and the body flaccid, he cuts the cord immediately and removes all mucus from the throat, at the same time pushing forward the base of the tongue so as to cause an elevation of the epiglottis. He then practises artificial respiration either after his own method or that of Sylvester, starting with a movement of prolonged expiration. There is no better method than his own for clearing the mouth and respiratory passages of mucus. After having performed the movements of inspiration and expiration eight or ten times in a minute, he plunges the child into a hot bath. If there is no response to this, he recommences the respiratory movements. Spontaneous inspiration usually starts during an expiratory movement. He then places the child again in a hot bath, but, if the respiratory efforts are feeble, he uses cold water instead. The infant must never be considered to be out of danger until it has cried strongly, and continuously.

CHAMPNEYS (London) in a similar communication said that there were two stages of asphyxia: apoplectic, or livid; syncopal, or pale. The worst cases of asphyxia occurred in breech presentations, and hence the condition could not be attributed to pressure upon the head. The diagnosis of the stage of the asphyxia is important; almost all cases are "pale." He laid stress on the uselessness of reflex stimulation in such cases. The pupils are found to be widely dilated in profound asphyxia, and contract on the re-establishment of the respiration, but not of the circulation. The objects of artificial respiration are:—to remove foreign bodies from and to procure the patency of the air passages, to stimulate the circulation and to ventilate the lungs.

Removal of foreign bodies from the air passages can be accomplished by the use of the catheter or by manipulation. Of all methods by manipulation the method of Schultze alone assisted in obtaining the patency of the air passages. Traction on the tongue did not directly raise the epiglottis; tilting up the chin was useless in infants; bending the head backwards was also useless. The excitation of the circulation was dependent on the ventilation of the lungs, and pressure on the præcordia directly raised the blood pressure. Only two methods of manipulation were efficient for ventilation of the lungs: *i.e.*, the methods of Schultze and of Sylvester. In mouth-to-mouth insufflation of air there was danger of rupturing the lungs, of tuberculous infection, and also of inflating the stomach.

RIBEMONT-DESSAIGNES, after stating the essential indications to be fulfilled, said that for the more severe cases the best treatment was instrumental insufflation, and in order to carry it out satisfactorily the insufflator must be capable of aspiring mucus, and must convey to the lungs a supply of air in due proportion to their capacity. He has himself devised an insufflator to carry out these conditions. It is easy of introduction, it remains *in situ*, it enables the mucus to be easily aspirated, and the bulb with which it is provided enables the correct amount of air to be introduced.

LEPAGE said that he had tried rhythmical tractions on the tongue instead of mechanical insufflation, but had never found it succeed in cases where artificial respiration had failed.

WALLICH (Paris) stated that *post-mortem* examinations of infants who have died of asphyxia usually disclose the presence of visceral lesions of various kinds; he therefore considers that artificial insufflation with a tube is preferable to the more energetic procedure of Schultze.

DEMLIN said that he had seen the two procedures, of rhythmical tractions on the tongue and artificial insufflation, practised on parallel cases. The latter was always found to be the more satisfactory.

PINARD also could not consider rhythmical tongue tractions to be of use. He employs artificial respiration after Schultze's method and the laryngeal tube to remove mucus.

#### ASTHMA AND PREGNANCY.

AUDEBERT discussed the relationship of asthma and pregnancy, basing his remarks on three cases recorded by Halliday Croom, two cases by Chrambelent, and five cases by himself. He draws the following conclusions:—The disease doubles its intensity during pregnancy, and during the confinement the attacks may become particularly violent. The prognosis is serious for the mother (one death in seven cases), and also for the infant (two deaths). Contrary to what one would suppose, even very violent dyspnoea does not bring on uterine contractions. Three reasons are suggested to account for the attacks: pressure on the lungs, irritation of the pneumo-gastric, and a kind of "menorrhæmia." Whatever may be the pathology, the most effective treatment appears to be the administration of morphia and quinine. Obstetrically, it is best by inducing labour to deliver the infant as quickly as possible.

#### CONSERVATIVE TREATMENT OF UTERINE MYOMATA.

A. MARTIN (Greifswald) said that for some time he had advocated the treatment of myomata by myomectomy, and always adopts this method in suitable cases. When the

tumour is single or there are but few of them, when the body of the uterus is not too large, the adnexa healthy, and the patient not near the menopause, he chooses the abdominal or vaginal route, according to the situation of the tumour. The vaginal route is valuable for conservative operations, and especially in the case of sub-mucous myomata.

DMITRI DE OTT said that he has recently had great success in operating on tumours incarcerated in Douglas' pouch, and which some years ago would have been considered as inoperable. In fifty-two cases he had proceeded in the following manner:—As soon as the abdomen was opened he incised the peritoneal investment, and decorticated the tumour. He then plugged the resultant cavity tightly with a long strip of gauze, and brought the end of the gauze into the vagina through a small opening in the bottom of Douglas' pouch; he had only two deaths in fifty-two cases. He has also performed twenty-seven vaginal myomectomies with one death.

GOTTSCHALK described the cases for which he considers ligation of the uterine arteries to be sufficient treatment: viz., those in which the entire uterus is myomatous but does not exceed the size of an adult head, and medium-sized multiple interstitial myomata. It is a specially suitable operation when the patient is approaching the menopause. It is not applicable to intra-ligamentary myomata. When there are numerous anastomoses of the uterine artery, the latter must be tied not only close to the uterus, but also at its commencement near the hypogastric artery.

GOUILLOUD (Lyons) had endeavoured to ascertain the diminution in size of the uterus after ligation of the vessels by measuring the length of the cavity. In the first case which he measured, the cavity was 11 cms. in length before the operation, and two years later was only 6 cms. In another, a cavity of 8 cms. was reduced to 6 cms. at the end of a year and a half. In a third, the length fell from 9 cms. to 7.6 cms. in a few months. In a fourth from 9 cms. to 7 cms. in a short time; and in a fifth from 8 cms. to 7 cms. in an equally short time. He also drew attention to the good results of ligation of the uterine arteries in hæmorrhagic endometritis when curetting has failed.

SECOND expressed himself as a partisan of myomectomy, but he prefers the vaginal route. He operates as follows:—He draws down the cervix and divides it bilaterally as far upwards as possible. He thus gains free access to the uterine cavity, and can explore it thoroughly, including the part about the tubal ostia. He uses a cork-screw to fix and draw down tumours, and then by the aid of a double-edged knife cuts successive cones out of them until they are so reduced in size that he can draw them down externally. The resultant cavity is then



plugged with gauze, and the incisions in the cervix sutured. The indications for this operation are the same as for vaginal hysterectomy: the tumours must be capable of being drawn downwards, there must be no adhesions, and the uterus must not extend above the umbilicus.

POZZI was not able to agree altogether with Segond. He considered that trans-cervical enucleation of myomata ought only to be adopted in the case of small sub-mucous growths. In large tumours there is the danger of leaving a thinned uterine wall prone to slough. Abdominal myomectomy is, he considers, a good operation in the absence of contra-indications, such as a large tumour, multiple tumours, diseases of the tubes or ovaries, or the necessary opening of the uterine cavity during the operation. If hysterectomy has to be performed it should be total, and no portion of the cervix should be left behind.

TEMOIN (Bourges) said that he had been one of the first to introduce myomectomy. He considered, however, that it was but rarely required now, and that it would never displace hysterectomy. After myomectomy it is a common thing for a fresh myoma to grow from some nodule that has been left behind.

CULLEN said that he was a pronounced adherent of conservative methods. The fear of opening the uterine cavity appeared to him to be chimerical.

TUFFIER was glad to see that the majority of surgeons had become conservative, but to be really conservative one must recognise the entire extent of the lesions present, and to do this the vaginal route must be completely given up and all cases operated on through the abdomen. His technique differs from the ordinary method. In order to avoid hæmorrhage, instead of incising the capsule straight over the myoma, he makes an incision in the median, avascular, antero-posterior line of the uterus, through which he seeks for the myomata and extracts them. Enucleation performed in this way is comparatively bloodless, and the large cavities which are left contract up and efface themselves.

#### MYOMATA AND PREGNANCY.

HOFMEIER stated that he had studied 550 cases of uterine fibro-myomata, with a view to determine the influence of these tumours on pregnancy. Of the 550 patients, 114 were not married; of the 436 who were married, 117 were sterile, but some of these were over forty and had been married for fifteen years; 319 patients became pregnant. He draws the following conclusions:—

(1) The proportion of unmarried women suffering from myomata is not greater than that of unmarried women suffering from any other form of gynecological disease.



(2) Even if the proportion of sterility amongst married women with myomata is very high, compared with the ordinary proportion of sterile women (11 per cent.), it does not follow that this sterility is due to the myomata.

(3) As 224 patients out of the 550 had never conceived, and 70 had only done so once, the non-occurrence of pregnancy seems to favour the development of a myoma.

(4) The existence of a myoma hinders pregnancy very little, and does not very often affect the course of labour. Operative intervention during pregnancy is therefore rarely required, and can only become necessary at the end of pregnancy. With reasonable care, confinement and the period of dilatation are nearly always accomplished safely.

EUSTACHE (Lille) said that he considered that when the presence of a myoma rendered labour impossible, total abdominal hysterectomy should take the place of Cæsarean section or Porro's operation.

MARTIN (Rouen) could not agree with Hofmeier that myomata were so harmless during pregnancy. They frequently cause abortion, as well as being an obstruction during delivery. He would not hesitate to operate during pregnancy to remove pedunculated or even sessile tumours.

POZZI said that he had seen, between 1895 and 1900, 83 cases of myomata amongst 12,050 confinements. He had only to perform major operations in four cases. He only operated under very special circumstances, and considered that neither the size nor the situation of the tumour constituted an absolute indication for intervening.

#### CERVICAL METRITIS.

Pozzi, in a communication on this subject, formulated the following conclusions:—

(1) Acute or chronic inflammation of the cervix may persist for a long time without invading the body of the uterus.

(2) Acute lesions of the mucous membrane of the cervix easily spread to that of the body; and chronic lesions of the parenchyma of the cervix, of inflammatory origin, promptly react on the nutrition and anatomical condition of the entire organ.

(3) The operation of trachelorrhaphy ought to be abandoned. It is inferior to bi-conical resection of the cervix—more or less modified according to circumstances.

(4) There are a large number of cases of acute, sub-acute, or chronic inflammation of the cervical mucous membrane, in nulliparæ, which are associated with stenosis of the os externum and consequent insufficient drainage. The most important part

of the treatment of these cases is to re-constitute by operation, a permanent and sufficiently large cervical orifice.

DOEDERLEIN (Tübingen) said that the causes of inflammatory diseases of the canals and cavities of the body must now be sought for in microbic infection. Bacteriological researches lead us to believe that the external os forms the boundary between a lower portion of the genital tract which contains micro-organisms, and an upper part which does not do so. As a rule there are no microbes in the cervix or in the cervical mucus. Micro-organisms introduced naturally or experimentally are destroyed by the alkaline mucus of the cervix. The cervix, therefore, not only protects itself, but at the same time defends the uterus, tubes, and peritoneal cavity against the micro-organisms which live in the vagina. Among the pathogenic germs which may penetrate healthy tissues and set up inflammation, the gonococcus of Neisser and the *B. tuberculosis* are alone of any importance so far as the ætiology of cervical metritis is concerned. While gonorrhœal infection of the cervix is very common, tuberculous infection is very rare. The ordinary defence of the cervix is powerless against gonococci. It is recognised that lacerations of the cervix play a large part in the ætiology of non-infectious cervical metritis, as well as all those causes and diseases which produce metro-endometritis.

MENDES DE LEON (Amsterdam) also read a paper on this subject, and after discussing at length the nature and causes of cervical metritis, arrived at the following conclusions:—  
(1) Cervical metritis must not be considered, or treated, as an isolated affection, inasmuch as in the large majority of cases it is associated with a similar affection of the body of the uterus.  
(2) The term "cervical metritis" ought, in the majority of cases, to be replaced by the term "cervical endometritis," since the inflammation of the mucous membrane but seldom co-exists with a lesion of the deeper tissues.

#### THE EARLY TREATMENT OF ABDOMINAL SYMPTOMS.

At the West London Medico-Chirurgical Society, on October 6, 1900, Dr. F. F. SCHACHT, in his Presidential Address, emphasised the following points. The symptoms of the onset of acute abdominal trouble are frequently very obscure and uncertain, but are generally of an inflammatory nature; from the medical as well as from the surgical point of view their early recognition is most important, but an exact diagnosis is often, at first, impossible; very careful examination is essential, and while the diagnosis is uncertain, a routine treatment should be adopted consisting of absolute rest in bed, a fluid diet in small quantities, the avoidance of all aperients, and the administration of small doses of opium, usually in the form of hypodermic injection.

J. M. J.—J.

## THE NECESSITY FOR A SYNONYMOUS INTERNATIONAL MEDICAL TERMINOLOGY.

*La Semaine Médicale* for August 1 directs attention to the mistakes which arise from the various meanings attached to the same medical terms in different countries. In gynæcology, as in other subjects, people are far from attaching the same meaning even to the most ordinary words. A good instance of this is be found in the term "castration," which is sometimes applied to the removal of ovaries believed to be healthy, and sometimes to the removal of inflamed appendages—an operation more frequently termed "salpingo-oophorectomy." American authors, on the other hand, designate the removal of healthy ovaries by the term "normal ovariectomy."

The same lack of unity is met with in obstetrical nomenclature. The description of the pelvis—the starting point of obstetrical study—is affected by it. In naming the diameters of the brim, the oblique diameters are, in France, termed right and left according as they run from the right or the left ileopectineal eminence, while in Germany they are termed right or left according as they run from the right or the left sacro-iliac joint.

It is the task of the medical press to direct attention to this evil, and to endeavour to start an international attempt to correct it.

H. J.

## CONSERVATISM AND ITS INFLUENCE ON OPERATIVE TECHNIQUE.

MACNAUGHTON JONES (*Edin. Med. Jour.*, August, 1900) points out the very indefinite way in which the term "conservatism" is used, even now, in gynæcology. If the word be taken to imply the saving of life, the relief of suffering and the restoration of the afflicted to usefulness, procedures, apparently the most radical, may be the most truly conservative. Modern pathological research has proved that the ovaries and uterus pass through degenerative changes from conditions of benign into others of a malignant type, and that conditions of both types may exist with intermediate degenerative changes. Primary malignant disease may affect the adnexa, but the nature of such growth can seldom be determined before operation when, as is customary in many foreign clinics, a trained pathologist should be at hand to make a report upon the character of the diseased tissue. This, by Pick's method, may be done in a few minutes.

Ovariectomy for cystoma, long regarded as the one justifiable operation, was met, on its introduction, with the most bigoted opposition. The reaction from timorous inactivity to over-sanguine and ambitious interference has perhaps led to unwarranted neglect of methods other than the knife; palliative

measures have their proper sphere in pathological conditions that experience has proved may be cured without operation. Modern teachers of repute in no way justify the removal of parts capable of restoration to health and the discharge of normal function, but the circumstances of the patient must influence the decision of the surgeon, not only as to the necessity of an operation, but also as to its nature. There will always be a large number of women in whom genital disease has reached the stage in which operation alone affords a chance of relief from pain, a possibility of continued usefulness. Retroversion or prolapse, incontinence of urine and exhausting hæmorrhages, are among the disabling conditions from which the afflicted may, in many cases, be promptly and permanently relieved by operative procedures that are, in the truest sense, conservative.

Curettage, usually considered a conservative procedure, may, in improperly selected cases or if imperfectly performed, be quite the contrary. It is, for instance, eminently successful, and therefore conservative, in benign decidual degenerations after abortion; in malignant degeneration of the chorionic villi vaginal hysterectomy is the true conservative operation.

The propriety of removing adnexal tumours is perhaps the question upon which gynæcologists have most widely differed. The tendency now is not to sacrifice any ovary or tube which can, with reasonable safety to the woman, be preserved; when the adnexa present *objective* signs of disease, the responsibility of leaving them alone is greater than that of exploring to determine the nature of the lesion, and advising their removal if convinced of its danger.

#### DISINFECTION OF THE HANDS.

By LABUSQUIERE. *Ann. Gynec. Obst.*, 1900, June.

Communications by M. Quénu to the *Société de Chirurgie* (*Sem. Méd.*, March, 1899, p. 109) on the above subject and operative asepsy has given rise to investigations and to a discussion which is not yet closed—various diverging opinions having been emitted by eminent operators; but the following general conclusions may be taken as the outcome of these investigations:—(1) That the combination of the two methods of disinfection, mechanical and chemical, is distinctly superior to purely mechanical disinfection (water, soap, and brush); (2) These investigations do not warrant us in formulating a definite judgment upon the comparative value of various disinfectants. The definite result of the disinfection depends upon various circumstances, such as the previous preparation of the skin, the facility with which this can be penetrated by such disinfectants varying greatly in different individuals.

A communication from Pierre Delbet upon the subject lays



down the following rules:—The important conditions in disinfection are to use very hot water, so as to dislodge and facilitate the emulsion of even sebaceous fat; but the quantity of soap used should be proportionately larger than the water, so as to form a thick lather which dissolves the fatty substance more readily. This soap washing should last about five minutes.

Then the hands should be washed in alcohol at 90 per cent. by means of a brush, until the antiseptic solution (usually Liquor von Swieten) will flow freely over the skin without assuming a spheroidal state, and will wet the skin intimately.

Practice has shown that this sterilisation of the hands is sufficient from a prophylactic point of view. Absolutely speaking, it is imperfect in the sense that a good microbiologist can still find some germs to cultivate, but which have suffered a check by the antiseptic application which attenuates their virulence.

Dr. SARWEY (Tübingen) stated that absolute sterility of the hands of the surgeon was not obtained by any of the various methods recommended for that purpose. The relatively best results were got by the use of hot water and alcohol (Ahlfeld's method) or by the use of spirit of soap (Mikulicz's method). Mere mechanical treatment of the hands with marble soap was not sufficient, disinfection with chemical agents being indispensable.

Dr. VOLLBRECHT (Düsseldorf) recommended a solid compound which contained spirit of soap, and might be used in the form of tubes. The use of indiarubber gloves as employed by Mikulicz was strongly recommended by Professor Sprengel.

P. Z. H.

#### KRAUROSIS VULVÆ.

HELLER, Charlottenburg (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 2), gives the case of a spinster of 59 who had suffered from this affection for ten years. By touching the horny plates of the well-marked kraurosis with formalin, and painting it daily with ichthyol, complete clinical relief was obtained. For diagnostic purposes he cut out a large plate and the part including the clitoris and submitted it to histological investigation. He explains the affection as a chronic process of inflammation set up by various kinds of irritation; in the deeper tissue it leads to the disappearance of the gelatinous matter, fat and sebaceous glands, and in the more superficial layers to hypertrophic processes, especially to hyperkeratosis, which takes place in a normal way and is not a parakeratosis.

#### THE FORMATION OF AN ARTIFICIAL VAGINA.

SITSINSKY, St. Petersburg (*Monats. f. Geb. u. Gyn.*, Bd. xii., S. 35), gives a comprehensive review of the question of artificial

construction of the vagina, embracing all the various methods that have been tried in this century, and describes an operation recently performed by v. Ott, which included the removal of a myomatous uterus. The patient, twenty-eight years old, had never had any catamenia but had for four years complained of molimina menstrualia. In place of a vagina there was a shallow groove divided into two parts by an obliquely directed fold of skin 2 to 2.5 cm. high. An enlarged uterus suggested hæmatometra. The wall of the bladder was in immediate contact with the rectum; there was nothing to indicate a vagina.

v. Ott split the fold of skin into two flaps, and without using the knife, forced his way from this wound to the uterus. Instead of hæmatometra, he found and removed a myomatous uterus without any cavity. The flaps of skin were turned back into the canal thus formed and securely fastened to the peritoneal opening, which was then closed. They healed in position, and a year and a-half later the artificial vagina was hardly to be distinguished from a natural one.

#### THE THERAPEUTICS OF DISORDERS OF MENSTRUATION.

MACNAUGHTON JONES (*Edin. Med. Jour.*, July, 1900) in discussing the hygienic, medicinal and operative treatment of menstrual disorders, recommends, in case of absence or suppression of the catamenia, cycling and other outdoor sports in moderation, a course of Swedish, or other suitable, gymnastics, and massage. These measures may be supplemented by galvanism or faradisation, internally or externally, or a course of hydropathic treatment at a recognised Spa. In some instances, especially when dysmenorrhœa is associated with amenorrhœa, a full Weir-Mitchell course is very beneficial, but this "blood-making" panacea, when adopted without due consideration, not infrequently does more harm than good.

As regards medicines, senecin (2 to 6 grs.), alone or with hydrastinine, is useful in amenorrhœa and dysmenorrhœa; in congestive or spasmodic dysmenorrhœa it should be combined with the bromides. Hydrastis is now very generally used in atonic conditions, and the hydrochlorate of hydrastinine is one of our most valuable astringents in uterine hæmorrhage. Manganese dioxide, especially if combined with ferrous carbonate, is undoubtedly effective in amenorrhœa with anæmia. Monobromate of camphor may, when there is ovarian pain, be added to other remedies. Of the coal-tar series, antipyrin or phenalgin will give most relief to dysmenorrhœal pain. If there be irregular or enfeebled action of the heart with deficient compensation strophanthus or digitalis is indispensable.

In regard to surgical measures, depletion, dilatation, section of the cervix, and the operations of Sims and Dudley, all have

their special indications, but displacements, hyperplasia, endometritis, interstitial or submucous myomata are causal factors frequently met with, and should be dealt with on broad surgical principles; with modern methods and antisepsis there is no excuse for procrastination in the treatment of conditions that imperil, sooner or later, not merely the organ affected, but life itself.

#### TWO CASES BEARING ON MENSTRUATION.

By ARTHUR GIBSON, *Glasgow Med. Journ.*, August, 1900.

(1) M. R., aged 23, unmarried. On examination under chloroform there was a sinus in the left groin over the region of the internal abdominal ring, through which a probe passed downwards and inwards to a distance of three inches. *Per vaginam*, the cervix pointed markedly to the right, and there was hardening and thickening of the left broad ligament. *Bimanually*, the fundus uteri was fixed in the left side and in front, and could not be clearly defined, as it was blended in the hardened tissues through which the sinus passed. Six months previously a surgeon had removed what he diagnosed to be a tubercular gland from the left groin. The wound healed, but broke down on her second day out of bed, six weeks after operation. A sinus formed, and at each period there had been a discharge of blood from it; pain and tenderness also increasing at such times.

Gibson concluded that the left Fallopian tube opened into the superficial portion of the sinus, and so prevented it healing. The abdomen was opened by an incision three inches long, parallel with and half an inch above Poupart's ligament. The ovary and tube on the right side were normal. Minor incisions facilitated the removal of the left tube. No ovary could be detected; but the cicatricial tissue all round the tube was so dense that it might have escaped identification, or there may have been a hernia of the ovary originally, and the surgeon may have removed the ovary in mistake for a tubercular gland, leaving the Fallopian tube in the wound. Galt examined the specimen microscopically, and it appeared to consist entirely of Fallopian tube embedded in cicatricial tissue. There was no evidence of tubercle, nor had the patient any signs of tuberculosis whatever. Recovery was complete, though somewhat retarded by the formation of secondary sinuses, probably due to infection from a wound of the sigmoid flexure, which occurred during operation.

(2) Mrs. R., aged 27, had had the ovaries and tubes removed two and a half years previously. She had since menstruated regularly, and also stated that her sexual appetite was in no way impaired.

H. M. M.—J.

OVULATION WITHOUT MENSTRUATION.—INFANTILE UTERUS.—  
CYST OF THE RIGHT OVARY.

MUNRO KERR (*Glasgow Med. Journ.*, July, 1900) had sent to him a patient, aged 23, who had never menstruated, though well developed mentally and physically and though, from the age of sixteen, she had suffered at regular intervals from severe pain, and experienced the feelings which commonly accompany menstruation. The uterine cavity was one and a half inches in length, and a sausage-shaped swelling occupied the upper part of the right broad ligament. Munro Kerr removed the ovaries. The right was cystic. The left presented Graafian follicles in various stages of development. The conclusion drawn is, that a well-developed uterus is essential to menstruation.

H. M. M.—J.

CLIMACTERIC INSANITY.

DAWSON, (*D. M. J.*, August, 1900, says,) "Insanity arising at the menopause usually takes the form of a weak depression with listlessness, vague fears of impending misfortune, and sometimes suicidal tendencies, the group of mental symptoms, in fact, in greater or less degree characteristic of all cachectic states." As exceptions to the general rule he records: (1) an instance of acute mania, (2) one of excited melancholia, and (3) one of chronic delusional insanity about the time of, and attributed to, the menopause.

THE CORRELATION BETWEEN SEXUAL FUNCTION, INSANITY,  
AND CRIME.

MACNAUGHTON JONES (*Brit. Med. Jour.*, September 22, 1900), in introducing this subject for discussion at the Ipswich Meeting of the British Medical Association, pointed out that the clinical evidence of the physical effects of the physiological function of ovulation in certain women, and of aggravated mental trouble due to various forms of erratic menstruation, is overwhelming. Gynæcological literature is full of records of hystero-psychoses and neuroses due to abnormal conditions of the sexual organs of women. There is therefore no doubt that disorders and diseases of the female genitalia frequently lead to disordered innervation, and the question arises whether they may not also lead up to the more serious forms of insanity, and also (1) whether sexual disease or disorder should not be clinically determined (or excluded) as a first step in the prognosis and treatment of insanity in women; (2) how far in the presence of such disease or disorder, gynæcological examination and treatment is indicated; and (3) whether if it fail to benefit the patient, such examination and treatment is likely to affect her mental recovery.



He alluded to the influences of sexual development during adolescence in causing mental disturbance in the male, and the evidence, also in the male, of an approaching or existing climacteric and the premonitory symptoms of insanity at this time of life, as interesting subjects for enquiry, as well as the legal responsibility, especially during adolescence and at the menopause, of a woman suffering from sexual disturbances which, it has been asserted, ought to be accepted as extenuating if not exculpatory circumstances.

In a more recent article (*Edin. Med. Jour.*, October, 1900) entitled, "Affections of the female genitalia as causal factors in the etiology of neuroses and insanity, and their special bearing on the operative treatment of the insane," he gives a somewhat amplified statement of the conclusion drawn in his former paper, as follows:—

(1) Where, in an insane person, ovulation and its external manifestation, the menstrual discharge, are absent or erratic, the erraticism or absence may be a consequence of the general and insane condition, and not a causal factor in its production; but under any circumstances such abnormal menstruation appears to have an aggravating effect on the insanity, and there is sufficient evidence to strengthen the belief that when such irregularity exists—especially if it be due to a pathological cause—it should be treated therapeutically or by operative measures.

(2) The question of a gynæcological examination of an insane woman must be a matter for the discretion of the psychologist, influenced by the gynæcological view as to its expediency from the signs and symptoms present in the sexual organs. For many reasons, as a *universal* practice, in the present state of our knowledge it is not warrantable.

(3) Sufficient evidence is now advanced to justify the removal of the adnexa or tumours of the uterus in insane women, when there are gross lesions of the former or tumours of the latter. Here, again, such operations must be advised according to the psychological condition of the patient and the type of her insanity.

(4) From a mass of evidence, including some of the largest experiences in Europe, Canada, and America, it does not appear that there is in healthfully-minded women, who suffer from diseases of the genitalia, any special risk of post-operative insanity. On the other hand, if there be a psychopathic predisposition, which has existed prior to and independently of the sexual disease, there is in such cases a larger percentage of post-operative mental disturbances than follows other operations. In such women the prudence of a radical operation may have to be carefully discussed. The post-operative mental effect does not appear generally to be of a serious or permanent nature.

(5) It may be generally affirmed that when mental disease of a graver type follows upon sexual disorder there has been in the woman affected an underlying and often unrecognised psychopathic predisposition; the disorder of menstruation or the disease of the genitalia completing the chain of the vicious circle needful for the final manifestation of the mental condition.

(6) The relation of aberrant sexual function or a disorder of menstruation to any criminal act ought to be taken into consideration in determining the responsibility of the woman.

At the Ipswich discussion, Dr. WYNN WESTCOTT, the Coroner for North-East London, mentioned that of 700 suicides on which he had held inquests, 200 were women, of whom the greater number had killed themselves about the change of life; most of the younger women were menstruating at the time of their suicide.

#### THE RELATION BETWEEN DYSMENORRHŒA AND APPENDICITIS. BY ARCHIBALD MACLAREN.

*Amer. Jour. Obst.*, July, 1900.

In this paper the author discussed the influence of pelvic inflammatory conditions on menstruation, and says: "In cases of cystic ovaritis and ovarian abscess I have seen some particularly satisfactory results following the removal of overlooked appendices. In 200 laparotomies I have 158 cases where inflammatory appendages had to be removed, and in 40 per cent. of these the appendix was diseased. The conclusion to be drawn is that the trouble had originated in the appendix and spread to the ovary and tube. During the same time I have operated upon seventeen cases of appendicitis in which there was no evidence of extension of the inflammation. I do not in every case advocate the removal of the appendix." In the discussion which followed SKENE said that the paper explained certain observations which he had been unable to account for, of ovarian pain undoubtedly caused by appendicitis, and which had disappeared when the appendix had been removed.

LAPTHORN SMITH mentioned that in nine or ten cases where he had operated for tubal pregnancy or pus tubes he had found the appendix firmly embedded in the tumour. In one case of tubal pregnancy the specimen could be held up by the appendix. The salpingitis caught from the appendicitis, was probably the cause of the tubal pregnancy. This question has an important bearing upon the question of pus tubes in young women.

J. F. J.

ACUTE SENILE ENDOMETRITIS. BY L. H. DUNNING.

*Annals of Gynecology*, August, 1900.

Two cases are reported, in both instances of women 63 years of age, in whom the menopause had occurred many years previously. The clinical history, in the main, was identical in both cases. The women had been well till a short time previous to examination, when a uterine discharge began, which at first thin and irritating, soon became sanguineous and offensive. Pain, general lassitude and rapidly growing ill-health supervened. There was backache, bearing-down pain and some vesical disturbance. The skin was dry and sallow. In one case the uterus was in normal position, in the other retroverted. There was senile vaginitis in both. Hysterectomy was done in each case; both uterine cavities were distended by a foul-smelling, sanguino-purulent fluid. A thorough examination was made of both uteri, and the author gives the following conclusions:—

- (1) The lesion found in both uteri was an acute inflammation.
- (2) The characteristic pathological features of the inflammation were (a) a thickened endometrium, the free surface of which was devoid of its epithelial layer; (b) increased vascularity with peculiar arrangement of small blood vessels; (c) small round cell infiltration; (d) diminished glandular elements; while a few glands were distinctly to be seen, in many of them, the epithelium was desquamating and their lumina were filled with granular *débris*; (e) degeneration of the coats of the arteries of the muscular layer; (f) in not one of the sections from various parts of the organ examined could any connective tissue be found.
- (3) The mucosa of both cervix and body were involved in the inflammation, which was in both cases more marked in the body.
- (4) The small round cell infiltration extended into the muscular tissue, the inflammation was more marked in the mucosa.
- (5) In both there was a cystic ovary, and in one a Fallopian tube was inflamed; and there were adhesions from peritonitis showing a tendency of the inflammation to extend beyond the uterus.
- (6) In one case the acute attack seemed to have been an exacerbation of chronic disease.
- (7) In neither case was there any marked stenosis of the internal os, though there was a considerable accumulation of fluid within the uterine cavity.

J. F. J.

ATMOKAUSIS AND ZESTOKAUSIS.

STOECKEL, Bonn (72 *Congress Nat. u. Aerzte*, Sept. 17, 1900), pointed out that Pincus' technic was capable of improvement.

Preliminary dilatation is necessary, and confinement to bed only rational. The field for atmokausis is uncomplicated hæmorrhage without any definite cause, *i.e.*, excessive menstrual climacteric bleeding, and such as depends on hæmophilia. The capability of the uterus to contract satisfactorily is a preliminary condition for success. For myoma, atmokausis is irrational, because the uterine contractions are irregular and deficient, and moreover because the tumours greatly alter the form of the uterine cavity so that, from purely mechanical reasons, it is impossible for the steam to reach the whole of its surface. In abortion, atmokausis is to be absolutely rejected; the curette and tampon give excellent results. In gonorrhœa no disinfecting action can well be attributed to atmokausis, the possible duration of its application being too short to admit of its affecting the deeper tissue. In dysmenorrhœa the use of atmokausis is not to be recommended, the preliminary dilatation has a far better effect.

#### UTERINE HÆMORRHAGE TREATED BY FORMALIN.

GERSTENBERG, Berlin (*Centralb. f. Gyn.*, 1900, No. 34), on an experience of ten cases, recommends the method proposed by Menge of treating uterine hæmorrhage by intra-uterine application of formalin. A Playfair's sound wrapped in cotton-wool is dipped in undiluted formalin (40 per cent. solution of formaldehyde) and the entire surface of the uterine cavity is rapidly swabbed out with it; the vagina is cleaned out and a tampon inserted against the external os. The application may be made in the consulting room, and the patient can return home after five minutes, but should then remain in bed for a couple of days. His own cases included climacteric hæmorrhages, hæmorrhagic endometritis after abortion, irritable and inflamed adnexa, puerperal subinvolution, &c. They all did well and he met with no stenosis.

#### PARALYSIS OF THE NON-PREGNANT UTERUS.

KOSSMANN, Berlin (*Münch. med. Wchns.*, 1900, S. 394), when making a curettement preliminary to intended colpotomy, was astonished to find the curette pass 13-14 cm. into the uterus. In the subsequent colpotomy he was able to satisfy himself that the uterus was not perforated, and supposes that there had been a sudden paralysis of the uterine muscular tissue, under which the organ became like a loose pouch.

#### THE SURGICAL TREATMENT OF BACKWARD DISPLACEMENTS OF THE UTERUS.

FERRARI, Alessandria (*Lucina*, October, 1900), gives an account of four cases of retro-deviation of the uterus treated by a method which is so strikingly simple, and which has given



such good results, that he can confidently recommend its adoption. Every operation should be proportioned to the gravity of the lesion it is intended to cure, and being a firm believer in the great part played by the pouch of Douglas, as a space, and by the preliminary descent of the vagina in causing uterine displacements, he has aimed at finding means to rectify the want of support behind the uterus, and to remedy the vaginal descent. The method he recommends is very similar to that proposed by Sanger (*Centralblatt f. Gyn.*, 1888, No. 2), and is much simpler and more efficacious than shortening the sacro-uterine ligaments as advised by Kelly, Frommel and Polk. The great tendency of serous surfaces to adhere when kept perfectly immobile and in contact, and the influence which a certain degree of irritation has in favouring the production of adhesions, has led the author to hope that Sanger's method with some technical modification would be successful.

The patient is purged and given aperient enemata for two days before the operation, so as to completely empty the bowel; shaving, and disinfection of the vagina is carried out in the usual way. The posterior vaginal fornix is incised transversely to the extent of 6 cm., and the pouch of Douglas is opened. The finger is then introduced, and with the aid of the other hand externally the adhesions are broken down, and the uterus is drawn upwards and forwards into a good position. The pouch of Douglas is then lightly plugged to the level of the internal os with iodoform gauze, and the uterus is afterwards forced upward and backward against the sacral promontory by a tampon in the vagina. The bladder must be kept empty for several days by a self-retaining catheter, and the bowels undisturbed for ten days by giving a purely liquid diet, and by opiates if necessary. After the ten days the bowels are opened by a clyster and a purgative.

The gauze is left in the pouch of Douglas for from two to four days, according to the amount of exudation. The vaginal tampon is renewed as required, every one or more days for a fortnight, the vaginal wound being washed with antiseptics every time the dressing is changed. The patient may wear a pessary for a month to prevent the recent cicatrix from stretching. Four cases are given, all with good results, though in one the separation of the adhesions was followed by severe hemorrhage.

The author says the simplicity of the method, its rapidity and absence of danger, are striking. The vagina is held up by the fixation of its posterior wall, and the uterus is glued to the posterior wall of Douglas' pouch. The essential point is to keep the uterus securely and firmly pressed against the sacrum for fourteen days.

F. E.

## COMPLETE PROLAPSE OF THE UTERUS IN ELDERLY WOMEN.

A. LAPHORN SMITH, in a paper read before the Canada Medical Association, concludes: (1) Women suffering from prolapse of the uterus out of the body, though not in much pain, are in very great misery. (2) There is some danger of the cervix becoming ulcerated, and of the ulceration becoming cancerous. (3) An age of 45, 50, or even 75, is no bar to operation. (4) These operations take only from twenty to thirty minutes, and are remarkably well supported by elderly women; even if we knew that the patients would live only one year afterwards, it would be well worth while operating for the sake of the comfort afforded them. (5) Vaginal hysterectomy especially is, in these cases, easy and safe, the mortality being not more than 1 per cent., probably not so much. (6) Ventrofixation gives good results when the uterus is short but not when it is long. In some cases the vagina and bladder pull down and elongate the cervix after the uterus has been firmly attached to the abdominal wall. (7) Either operation should invariably be followed by anterior or posterior colporrhaphy. (8) The patients should remain in bed for six weeks to give time for the new tissue to become strong.

## TORSION OF THE UTERUS.

V. WOERTZ, Vienna (*Monats. f. Geb. u. Gyn.*, Bd. xii., S. 68), reports a case of torsion of the uterus due to twisting of the pedicle of an ovarian tumour, and discusses in connection with it the other cases which have been published. The condition is as often due to myomata of the organ itself as to ovarian tumours, and is generally greater in the former than in the latter case.

V. Woertz agrees with Gebhard in wishing to confine the term "torsion" to the twisting of the uterus about its axis somewhere near the internal os, and to call the twisting of the uterus with the vagina "rotation."

A certain diagnosis can rarely be made before operation.

## HYDATID CYST OF THE UTERUS TREATED BY INCISION AND MARSUPIALISATION.

BARETTE (*Sem. Méd.*, July 11, 1900) operated on a patient, aged 21, for an abdominal tumour, which reached above the umbilicus, and was rapidly growing and causing pyrexia. After opening the abdomen and incising the reddish smooth wall of the tumour, which resembled uterine tissue; about three and a half litres of yellowish fluid escaped, containing ovoid flask-shaped masses resembling half collapsed grapes. As the wall

of the cyst could not be dissected out on account of its intimate connection with the uterine tissue, its edges were carefully sutured to those of the abdominal incision, the cavity was cleansed and plugged, and four drains were inserted.

The result was extremely good. The pouch grew gradually smaller, and the lining membrane became detached in small pieces. The drains were removed at the end of eighteen days, and the cicatrisation of the wound was complete in two months. Further examination of the fluid which escaped showed that it was manifestly a hydatid cyst.

H. J.

#### FIBROMYOMATA AND ADENO-MYOMATA OF THE UTERUS: THEIR DEVELOPMENT.

CLAISSE (*Thèse de Paris*, 1900, No. 215) bases the following conclusions upon 235 histological sections of 41 tumours, removed by operation at the Salpêtrière. (1) Neither heredity nor celibacy influences the frequency of fibro-myomata, but they are relatively more common among sterile women, the endometritis which precedes or accompanies them interfering with conception. (2) Uteri in which these tumours originate are, as a rule, the seat of sub-acute inflammatory lesions affecting the mucosa, and still more the smaller vessels of the muscular wall. (3) Round these vessels, and more usually about the capillaries, is developed a proliferating ring of round cells transforming themselves into smooth fibres; this ring grows by the formation of points of increase (proliferating cells and new capillaries), and surrounds itself with a fibrous band which isolates the myomatous nodule amidst the neighbouring fascicules. The central primitive vessel may at first dilate but soon becomes obliterated. (4) These new formations are essentially inflammatory; developed at the expense of endo- and perithelial elements, they are associated with analogous lesions of the peritoneum, adnexa, and above all of the uterine mucosa; they entail a marked leucocytosis. They are probably due to microbes, although the presence (not constant) of germs in the tumours, their suppuration and that of the parts about them, do not afford absolute proof; they are perhaps sometimes due to the local action of poison, either microbial or otherwise. The injurious elements find an entrance through the lymphatic or hæmal circulation, and generally through the mucosa. (5) Interstitial tumours during their development are not intimately connected with neighbouring tissue; subperitoneal and submucous tumours compressed by the uterine muscle tend to project from the free surface and to form pedicles. (6) Their structure varies; their tissue, at first almost entirely muscular, becomes interspersed with connective fascicules, and frequently the fibrous tissue comes to pre-



dominate; the increase takes place around the vessels in a way analogous to the primitive formation. (7) A uterus which contains such masses as to be fibromatous will have undergone other transformations; the wall hypertrophies and surrounds the new growth with a thick shell separated from the tumour by a loose (*lache*) capsule; the mucosa exhibits the lesions of hypertrophic, or sometimes atrophic endometritis; tubes and ovaries are often affected. (8) Fibromyomata may regress in the absence of irritation or augment indefinitely in volume; they may undergo aseptic transformation (*œdema* by compression or vascular obliteration, cystic formations, calcifications, necrosis, &c.) or septic changes (suppuration of the capsule or even of the tumour, gangrene of polypi) or malignant degeneration (sarcomatous); carcinomatous degeneration has not been met with. (9) Glandular polypi are developed at the expense of a local hypertrophy of the mucosa of an inflammatory nature; they embrace the different epithelial and connective elements of the mucosa. (10) Interstitial adenomyomata may be of congenital origin (inclusion of the canaliculi of the Wolffian body, or of Müller). They may also begin in hypertrophy of the uterine mucosa, by pinchings up and prolongations of the mucosa and inclusion of the glandular islands so formed; the muscular fascicules undergo simultaneous proliferation round the adenomatous centres. The structure of the glandular islands is the same as that of the mucosa. These tumours have no capsule. They may also develop in the horn of the uterus by pinching in and inclusion of the mucosa of the tube; pseudo-glandular proliferating formations may originate in this way. Adenomyomata may become cystic or telangiectatic, or may change into malignant epitheliomatous tumours. (*cf. infra* p. 135, Fibromyomata and Cancer, "As Claisse says.")

#### FIBROMYOMA AND CANCER.

*Lille Journ. Sc. Med.*, September 22, 1900.

De VERSTRAETE, who wrote a thesis on this subject in 1899, reports a case of fibromyoma and cancer of the body of the uterus associated with epitheliomatous degeneration of both ovaries, the right one being also affected with a large cyst, and points out the relative frequency of the concomitance of cancer with fibroma of the uterus. He has collected eighty-eight cases.

Prof. PAUCHET (*Gaz. Med. Picardie*, August, 1899, p. 263) states that most of the cases of cancer of the body of the uterus which he operated upon originated in small fibromatous uteri, which, after a quiescent condition of several years, had eventually given rise to sanguineous discharges and pain, indicating malig-



nant transformation. Five of his specimens were fibromatous uteri with their cavities packed with cancerous vegetations. His conclusions are as follows:—

(1) He only operates in early cases.

(2) He removes *en bloc* the whole uterus by the abdominal method.

(3) He advocates the removal of all fibromata, if only as a dangerous nidus for cancerous development.

As Claisse says, "When a uterine fibroma has been recognised and a vaginal discharge of a serious, often offensive character is observed, with occasional violent hæmorrhage and paroxysms of intense bearing-down pains, these symptoms, especially if they are observed at the time of the menopause, should arouse a suspicion of malignant degeneration of the uterine mucosa, which direct examination will often confirm."

Experience has shown that total abdominal hysterectomy gives the best results, several cases of partial removal having been observed to require a second operation from the return of the malignant process in the stump.

P. Z. H.

#### MYOMATA AND THEIR COMPLICATIONS, ESPECIALLY VARICOSITY AND NECROSIS.

FREUND, Strasburg (72, *Versammlung, N. u. A.*, September 17, 1900) drew attention to two processes, well defined and capable of diagnosis, the knowledge of which is of very great moment in regard to the indications technic and prognosis of operations for myomata:—

(1) *Varicosity*.—A congenital, and sometimes hereditary, disposition to the formation of varices, more particularly manifested in the pelvic organs and lower extremities, may exist, and in women such a predisposition affects, in case of pregnancy or myomata, not only the course but the prognosis of any operation as one is apprehensive that hæmorrhage may be hard to control. In one case, fatal immediately from free bleeding after operation, the field of the hypogastric vein was found at the autopsy to be a mass of blood channels; in two others, after well-executed operations, he saw death under the following conditions:—Rapidly increasing pain in one side of the pelvis, with impulse to stool and pass water: with this there was normal temperature, a hard, accelerated pulse and nervous unrest; then suddenly, with a feeling of relief and subsidence of the pain, rapid loss of strength. In both cases the abdomen was immediately reopened and disclosed considerable hæmorrhage from an open large pelvic hæmatoma and stripping off of the ligatures on the broad ligament. The veins beyond the ligatures had bled into the connective tissue. The bleeding continuing, the thrombus forced

its way outwards on all sides, even against the ligatures, finally stripping off the latter and tearing them away from their attachments.

(2) *Central Necrosis of a Myoma*.—Patients with myomata are sometimes seen to deteriorate gradually for years under symptoms of chronic, gastric and intestinal catarrh, headache, nervous irritability, hypochondriasis, giddiness, sleeplessness, depression and palpitation of the heart, sudden starts. Their complexion becomes a dirty pale yellow, their muscular tissue flabby, their tongue foul. Diarrhœa alternates with constipation, and their urine deposits much sediment; there is no fever. Examination discloses arterial sclerosis, with weakening of the heart's impulse; a corpus uteri infested with multiple myomata and tender; no definite signs of pelvic peritonitis, but increased flow and prolonged discharges of blood. Operation removes a uterus with numerous soft myomata, in the centres of which are necrotic foci, from pale yellow to reddish-brown in colour, and which, in the highest degree of change, give out an odour resembling propylamine. Microscopical sections never show pus, bacteria, or cocci. On recovery from operation the patients are at once and completely relieved of all the symptoms above described. Freund looks upon this form of disease as an auto-intoxication. In his last case, in which central necrosis had been diagnosed before the operation, acetone had been demonstrated in the urine.

HAMMERSCHLAG, Königsberg (*Monats. f. Geb. u. Gyn.*, B. xii., S. 8), describes four cases of interstitial myomata which had undergone changes in childbed and were operated on soon afterwards. Microscopical examination of the specimens enables him to separate the changes in the tumours into four stages: (1) simple necrosis of the myoma without demarcation; (2) necrosis with softening; (3) necrosis with limited suppuration; (4) putrefaction and elimination. The larger the growth the sooner extensive changes may be expected.

#### MYOMATA AND DIABETES.

KLEINWÄCHTER (*Zeitschrift. f. Geb. u. Gyn.*, Bd. xliii., Heft 2) has collected the histories of the six instances of this complication which have hitherto been recorded (one by Lob, two by himself, and three by Gottschalk). The diabetes was in some severe and rapidly fatal, in others of a milder form; it was associated with tumours of small size, and also with large ones and severe hæmorrhage; it sometimes did not occur till long after the myoma had been present, in other cases it accompanied, or soon succeeded, the development of the tumour. As yet no causal relation can be established between the myoma and the

diabetes; in the case of large tumours with severe hæmorrhage such a causal relation may, Kleinwächter thinks, be accepted; for smaller tumours other explanations are more probable. Extirpation of the uterus is not indicated unless the tumour itself demands such intervention.

#### MYOMATA AND THE CLIMACTERIC.

SCHAUTA, at the Vienna Obstetric and Gynæcological Society on February 26, 1900, said that it was generally admitted that at the climacteric myomata ceased to grow and give trouble. But what are we to understand by the climacteric? Anatomically it is the arrest of the function of the ovaries, which is by no means necessarily coincident with the cessation of hæmorrhage. To our women, in our climate, the climacteric generally comes about their forty-eighth year. In the presence of myoma it is almost the rule for the bleeding to go on till the fifty-third year, or even later. In myomatous cases, therefore, it is a question whether bleeding in the fiftieth year may be catamenial or pathological. Cases of myoma are met with in which the bleeding does not stop at all, and you may wait as long as you like for the climacteric, the tumours get bigger and the hæmorrhage more profuse; the hæmorrhage, in fact, comes from the tumour itself, which is a bleeding myoma; so that Péan's statement that myomata grow even in the climacteric, really depends upon the definition of what the climacteric is.

In regard to the cachexia, great weight must be given in forming a diagnosis to the general condition and appearance of the woman. No doubt when malignant tumours are associated with hæmorrhage and anæmia, the patient's unhealthy appearance is due to these latter, and it must be admitted that in many cases the women are also septic. There are other cases, not complicated by anæmia due to hæmorrhage or any sepsis and nevertheless, of such aspect that one is struck at the first glance, and convinced that very serious changes are proceeding in the systems of those persons, that in all probability there is a malignant new growth. The impression given to himself had always suggested that such malignant neoplasms produced a chemical poison, to the depressing action of which the profound debility was due.

#### LARGE MYOMA OF UTERUS REMOVED BY ENUCLEATION.

MUNRO KERR (*Glasgow Med. Jour.*, July, 1900) had to reopen the abdomen in this case in order to arrest hæmorrhage. The adhesions were such that the tumour appeared to derive its blood supply from the abdominal wall rather than the uterus. The tumour was also closely adherent to the



transverse colon and meso-colon. These latter adhesions accounted for an unusual feature in the history of the case, viz., an increase in the severity of pain after food, or purgatives. (For conservative treatment of myomata *v.* Paris Congress, *supra*. p. 116).

H. M. M.-J.

#### FIBROMATA IN AGED PRIMIPARA.

BIGEX (*Thèse de Paris*, 1900, No. 505) concludes from studies at the Clinique Baudeloque that fibromata of the uterus are common in primiparæ, over 30, and have been found in 11.19 per cent. of such. The infants developed in such fibromatous uteri are, in average weight, inferior to those of other primiparæ. These tumours prolong labour; are often the cause of obstetric intervention. Pinard mentioned the danger that an erroneous diagnosis may cause—the tumour may be taken for another fœtus. In one case he found a colleague had passed the tape over two pediculated tumours, supposing them to be feet, and tired out by prolonged futile traction, had sent for him. The woman died within twenty-four hours. (For fibroma in pregnancy *v.* Paris Congress, *supra*. p. 118.)

#### TREATMENT OF TUMOURS COMPLICATING PREGNANCY.

By BROOKS H. WELLS. *Amer. Jour. Obst.*, May, 1900.

Impregnation frequently occurs in the early stages of cancer, and two-thirds of the cases go on to term. Under the stimulus of pregnancy the cancer grows, and the cachexia rapidly increases. Some of the women die before term from exhaustion, or from septic infection from the breaking down cancer tissue. Should they abort there is increased risk from sepsis and hæmorrhage, and should they go on to labour at term, over 30 per cent. succumb when delivery occurs spontaneously, and 50 per cent. die when artificial aid has to be given, while 40 per cent. of the children are born dead. In the presence of cancer of the cervix it is usually impossible to be certain of pregnancy before the end of the third month. Here the child should be entirely ignored; while the uterus is yet small it should be removed with the upper part of the vagina, by vaginal hysterectomy or by Werder's operation. When the conditions are favourable the vaginal operation is best, but when the disease is more advanced or the body of the uterus is enlarged, Werder's method is advisable. This method is ideal in that it avoids any contamination of the peritoneal cavity, or of any cut surface, by septic or cancerous matter. When the condition is discovered during the fourth or fifth months of pregnancy, immediate combined hysterectomy is still the procedure of choice. When



the child is viable the choice lies between induced labour and hysterectomy or Cæsarean section and removal of uterus and vagina. If the case be not seen till term the cancer may be so slight as not to prevent dilatation of the cervix, but even then it predisposes to deep tears; if more advanced the disease may be scraped and cut away and dilatation aided by multiple incisions. Where the disease is extensive Cæsarean section and immediate removal of the uterus and vagina are indicated.

The chance of pregnancy is lessened by the presence of uterine fibroids, but the risk of abortion, which in these cases is particularly dangerous from hæmorrhage and sepsis, is increased. When stimulated by the increased blood supply incident to pregnancy, fibroids grow very rapidly; they also show an increased liability to inflammation and to cystic degenerations. Interstitial tumours grow most rapidly. Subperitoneal tumours do not grow so quickly and are not so important in their effect on labour. With submucous tumours pregnancy rarely occurs, when it does it ends in abortion. The higher the situation of the tumour and the more it approaches the subperitoneal type, the less the danger. In the presence of a fibroid proper, uterine retraction is interfered with and post-partum hæmorrhage becomes a serious danger. Malpresentations of the fœtus are more frequent. Rupture of the uterus is not uncommon, being favoured by the degenerative changes in the uterine wall, caused by the presence of the fibroid. Inflammation and sloughing of the tumour from the pressure and bruising, to which it is subjected during labour, is very common and brings with it most grave risk from sepsis.

*Treatment (before labour).*—With small subperitoneal tumours of the fundus and a pregnancy well advanced, expectant treatment is allowable, but during the early months myomectomy is indicated, and can often be done without interrupting the pregnancy. If the fibroid is low down enucleation *per vaginam* is best, since waiting exposes the patient to grave risks. With interstitial tumours of the body of the uterus supravaginal hysterectomy is better than either abortion or premature labour, and is easy because of the relaxation of the broad ligaments caused by the pregnancy.

*During labour.*—With fundal tumours it is only necessary to secure contraction during the third stage. If a fibroid in the anterior wall obstructs labour it may sometimes be pushed out of the way, with the patient in the knee-chest position. Tumours of the cervix must be enucleated when possible, as even when very small, enucleation is less dangerous than forcible delivery. A polypus should be removed. If the fibroid obstructing labour cannot be got out of the way, it is better to do a radical abdominal operation than to run the grave risks of sloughing

and sepsis, which may follow forcible delivery by forceps or version. To ensure success these operations should be done early, as matters of election, and not late, when the patient is exhausted, bruised and septic. If any sign of inflammation or slough appears after labour the tumour must be removed at once.

Ovarian tumours, when seen early in pregnancy, should be removed by abdominal section. After the fifth month, if the cyst be neither large nor impacted, it is right to wait till the foetus is viable before operation, but the patient must be kept under constant supervision. If the cyst be impacted Cæsarean section and removal of the cyst are indicated. The cyst should on no account be punctured and the child dragged past it, the mortality attending such a procedure being very great. In the author's experience abdominal operations are, in general, well borne during pregnancy, and are more easily done than one would imagine, owing to the elasticity of the tissues.

J. F. J.

#### LABOUR CASES COMPLICATED BY TUMOURS.

By ROBERT JARDINE, M.D. (*Glasgow Med. Jour.*, August, 1900.)

*Parovarian Cyst.*—(1) A I.-para, aged 25, first seen in the first stage of labour with a cyst about the size of an orange, probably parovarian, retained below the promontory by the descending head. Rupture took place upon the application of the forceps. The patient made a good recovery.

*Ovarian Cyst.*—(2) Dr. D. Christie, on examining a I.-para, aged 30, who had been seized with severe pain in the eighth month of pregnancy, found that an ovarian tumour the size of a large orange had descended in front of the uterus. He succeeded in pushing the tumour up. Jardine was then consulted, and operative measures discussed, torsion of the pedicle being suspected. It was decided, however, to wait and watch. The pain ceased, and the patient was delivered at full term of a living child, with forceps, but without difficulty.

*Suppurating Dermoid of Left Ovary and Intestinal Adhesions.*—(3) A XIX.-para, aged 39, had been four days in labour without passing a motion. On the third and fourth days vomiting had been incessant. On admission the patient was seriously collapsed, the vomit faecal, and the abdomen extremely distended. The child was turned and delivered. An oblong indistinct swelling then became evident to the left of the uterus. A very large enema was injected without effect. Jardine being uncertain whether he was dealing with distended bowel or a tumour, operated two hours later, and found a firmly adherent cyst of the left ovary. This burst during the necessary manipulations, and fetid pus escaped. Two inches above the adhesions about

an inch of the bowel was contracted to half its lumen, but examined *post-mortem* was found to be patent. The abdominal cavity was well flushed with normal saline solution, and a large quantity allowed to remain in it. The child died immediately on birth, and the patient six hours after operation.

*Fibroid Tumours.*—Cases 4 and 5 were fibroids of the uterus. In each the chorion was adherent all over. Case 6 might possibly have been a dermoid of the ovary. The child was dead. Delivery was effected with forceps, after perforation. Case 7, large fibroid completely blocking the brim of the pelvis, Porro's operation was performed.

*Tumours of the Vulva-Lateral Placenta Prævia.*—(8) I.-para, about six months pregnant. A mass of large, septic, warty growths, evidently of gonorrhœal origin, covered the vulva and encircled the anus. Jardin removed the growths entirely, and finding the os uteri sufficiently dilated, turned and delivered. The child died, but the mother did well.

H. M. M.-J.

#### FIBROMYOMA OF THE RIGHT ROUND LIGAMENT.

v. MARS, Lemberg (*Monats. f. Geb. u. Gyn.*, Bd. xii., S. 1) writes: a woman of 28, who had had three children, had remarked for about three years the growth of a tumour in her right groin, and latterly the growth had been rapid and had given her great trouble. On operation it was found that the hard, sausage-shaped swelling lay in the distended inguinal canal, corresponding to the course of which it traversed the abdominal wall. It was easily enucleated without injury to the peritoneum immediately next it. Its direct connection with the round ligament could not be made out, but from its position and microscopical structure (smooth muscular tissue). v. Mars attributed its origin to that ligament.

#### GENITAL FIBROMATOSIS.

JACOBS (*Bull. Soc. Belge Gyn. Obstet.*, No. 10, 1900) refers to the rarity of ovarian fibromata (cases of which were published by Borremann, *ibid.*, 3, p. 169), and records the following case in which the ovarian fibroma was merely a part of what was essentially a genital fibromatosis.

An old maid, aged 52, without any history of previous disease, and two years after an uneventful menopause, before which the catamenia had been normal in time and quantity, had sudden symptoms of peritonitis, and for the first time a large abdominal tumour was detected. Fifteen days later, after the peritonitic symptoms had, under the care of her medical attendant, passed away, Jacobs was consulted and diagnosed a large fibroma of the uterus incarcerated in the smaller pelvis.



On operating he found the tumour to be an ovarian fibroma, the pedicle of which had been twisted three times round with consequent necrobiosis and peritonitis. The tumour was covered with adherent and very inflamed intestines and, by the torsion of the pedicle, had been dragged down, and partially incarcerated in the smaller pelvis. A second fibroma with a broad base, about the size of a mandarin orange, grew from the posterior side of the uterus, throughout the muscular tissue of which many small fibromata were disseminated; and a third large tumour, attached by a broad pedicle to the supravaginal portion of the collum, had developed between the folds of the right broad ligament. This last was enucleated and total extirpation performed without any operative accident. Some sanguineous fluid, which had accumulated in the broad ligament, was discharged spontaneously nine days afterwards, otherwise the recovery was uninterrupted.

#### THE ÆTIOLOGY OF CANCER.

JÜRGENS (*Sem. Méd.*, July 25, 1900) at the Berlin Medical Society related how in the case of a patient who died of a pulmonary neoplasm he found in the cardiac tissue a large number of cellular forms resembling the protozoa he has already described (*v. Sem. Méd.*, 1896, p. 196). These elements were mostly found between the fibres of the left ventricle, and in greater number than in any of the numerous examinations of cardiac tissue which he had previously made. They appeared to him to be myxomycetes, and he is inclined to believe that they play a part in the development of cancer in its earliest stage.

H. J.

#### ADENO-SARCOMA AND THE MENOPAUSE.

DESPLATS, Paris (*Lille Journ. Sc. Méd.*, September 15, 1900), reports a case of mammary adenoma of ten years' standing in a robust country multiparous woman of 50, which degenerated into an adeno-sarcoma at the occurrence of the menopause. The patient entered "La Charité" Hospital March 31, 1900, and could give no history of any illness until seven months previously, when she had an attack of whooping cough, which lasted three months, at the same time as the menopause supervened. A small painless tumour, the size of a walnut, was observed about ten years ago outside the nipple of the left breast, which remained stationary until the middle of December, 1899, when it began to enlarge rapidly. The tumour was removed on April 2, and was about the size of a child's head, presenting the characters of adeno-sarcoma.

The author suggests the menopause as a cause of the pro-



liferation and degeneration of the tissues, but it seems more probable that the whooping cough infection of the blood created a modification in the nutrition of the original tumour, the tissues of which were already in a pathological condition, and thus brought about the degeneration.

P. Z. H.

#### MALIGNANT HYDATID MOLE.

SOLOWY and KRZYSZKOWSKY, Lemberg (*Monats. f. Geb. u. Gyn.*, Bd. xii., S. 15) give the following case:—A patient of 47, the mother of ten children the youngest 5 years old, was admitted for a suspected malignant tumour of the uterus. She had never aborted, and had been in good health with regular menstruation until about ten weeks previously, when she began to suffer from considerable and nearly continuous genital hæmorrhage with, latterly, abdominal and sacral pain. Labour pains came on, and through the dilated os uteri the presence of an hydatid mole was ascertained. In clearing out the mole it was found that the villi had grown through the right wall of the uterus and already extended into the connective tissue of the pelvis. The patient died under persistent hæmorrhage with septic symptoms, and at the autopsy the villi were found to have invaded the right spermatic artery, and that the new growth had from thence undergone further development. Excellent illustrations of the macro- and microscopic appearances accompany the article.

This case led Solowy to suggest at the 1899 Congress of the German Gynæcological Society, that in every instance in which an hydatid mole had existed beyond the first half of the term of pregnancy, the uterus should not only be cleared out, but should, as a preventive measure, be extirpated by the vagina without avoidable delay.

According to VAN DER HOEVEN, the syncytium of the chorionic villi comes from the foetal ectoderm, Langhans cells from the somatopleura. In a mole, either or both tissues may undergo proliferation, reminding one of the growth of malignant tumours. It depends upon the behaviour of the two whether the result becomes a syncytium, or a deciduoma, or a mixed form.—*Weekblad*, No. 8.

#### EXTIRPATION OF THE VAGINA.

BROSE, Berlin (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 2), describes a successful case of extirpation of the vagina and uterus, for carcinoma of the posterior vaginal wall, in a woman of 32. There was no reaction and there was, nine months later, no recurrence. In connection with this case he discusses the various methods of removing malignant new growths of the

vagina; the parasacral ways and the vaginal, as proposed by Schroeder, Dührssen, Mackenrodt, Olshausen, Winter, Sippel and Martin. He operates himself by Martin's method in which the vagina is cut round at the introitus and is detached from the parts surrounding it without further help from the knife. He recommends this method for most cases in which total extirpation of the vagina is indicated; more room when necessary may be obtained by the perineal incisions of Olshausen or Sippel.

Partial extirpation should be confined strictly to those cases in which the carcinoma has just begun, in all others extirpation must be total. In younger women suitable plastic operations such as proposed by Lipinski and Rosziewski may afterwards provide for the necessities of married life.

For surgical treatment of uterine cancer *v.* Paris Congress, *supra.* p. 119.

#### SARCOMA OF THE CERVIX WITH OVARIAN METASTASES, PREGNANCY AND ABORTION.

BORREMANN, Breslau (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 2), gives a detailed description of a giant-celled sarcoma of the cervix with metastases in both ovaries, taken from a woman of 30 who died from sepsis after abortion. The microscopic examination disclosed various forms of giant cells, but he could not determine whether the growth originated in the mucosa or the muscular tissue. He was not able to find any recorded case of uterine sarcoma in which the giant cells—which indeed are very often not met with at all—were so numerous, large and multi-nucleated as in this one, in which the principal points of interest are: (1) the diffuse extension of the sarcoma along the lymphatics and metastases; (2) the conception and the question of the size and extension of the disease when it occurred; and (3) the abortion. Ovarian metastases, carcinomatous or sarcomatous, are extremely rare; their presence in this case Borremann attributes entirely to the lymphatics, not deeming it necessary to suppose a reversed circulation for the tumour cells to have reached the ovarian through the lymphatic channels. The complication of uterine sarcoma with pregnancy is also extremely rare. This case is indeed only the fifth recorded instance of sarcoma of the cervix. The occurrence of abortion may be explained by already existing endometritis, or attributed, according to the theories of Kellmann and Knupffer, to the thickening of the cervix, caused by the growth of the sarcoma, directly irritating the cervical ganglia and so causing reflex contractions of the uterus.

## OVARIAN CYST WEIGHING 50 KILOS.—EXTIRPATION—RECOVERY.

ROUFFART (*Bull. Soc. Belge Gyn. Obstet.*, No. 10, 1900) reports the following case. A woman, aged 59, of small stature, and the mother of fifteen children, had had three miscarriages; confinements all easy and normal; menses normal, established at 11, ceased at 54, after which there had been no loss of blood till one year ago, when bleeding had recommenced more copious than the catamenial flow. For fifteen or sixteen years she had been aware of a small tumour in the umbilical region, which had gradually increased in size. Only in 1897 did she begin to have discomfort and pain, became bedridden and complained of attacks of suffocation and indigestion. Even to change her position in bed gave her excruciating abdominal pains.

In December, 1898, the bleeding became constant, and from August, 1899, the abdomen began to get larger very rapidly, till on examination, it measured 1.75 metres in circumference. An immense umbilical hernia contained a great part of the intestines, and entirely behind the bowels Rouffart found a large fluctuating tumour with all the character of an ovarian cyst. A cervical polypus as large as a foetal head, growing from the neck of the uterus, was discovered on bimanual examination.

On February 7, Rouffart opened the abdomen, detached the adhesions of the intestine to the lower side of the hernial aperture and, turning back the bowels, punctured the cyst, from which 35 litres of serous fluid was discharged into pails. The cyst was drawn into the abdominal incision and its adhesions to the under side of the liver, to the intestines and to the abdominal wall set free, but was found to contain a number of sacs full of white opaque gelatinous matter, which had to be sponged out before he could extract the fundus of the cyst wall. The cyst, with some sacs still unbroken inside it weighed 12 kilogrammes. The uterus was then removed with the other adnexa, the pelvic peritoneum closed, and, a drain having been inserted, Rouffart attempted, but had to abandon, the operative cure of the hernia, the entire surface of the sac being adherent to the intestine, and the patient enfeebled by the long operation. Part of the intestine was freed and the abdomen was closed. There was hardly any rise of temperature, and the woman was discharged on February 25, quite cured.

## CYSTOMA OVARIII GLANDULARE.

KOSSMANN, Berlin (*Münch. med. Wchns.*, 1900, S. 362), removed from a girl of 15 a colossal cystoma which had grown so rapidly as to enlarge the abdomen as quickly as pregnancy. Three months later a new tumour almost as large as the former one



necessitated a second operation; six weeks later a pseudo myxoma containing 6.8 litres had formed, six hours after the removal of which the patient died from cardiac failure.

WUNDERLI (*Brün's Beiträge*, Bd. xxvi., Heft. iii.), writing from the Canton Hospital of Münsterlingen, discusses the bacterial infection of ovarian cysts in connection with a case of a dermoid infected by the *B. coli*, some relevant experimental investigations, and twenty-four cases already published. He concludes that ovarian cysts may be infected by puncture, in consequence of inflammatory processes arising in the genital canal, or after typhoid fever, torsion of their pedicle, or spontaneously. A very few bacteria, once introduced, may by rapid multiplication convert the contents of a cyst into a most dangerous focus within the patient's peritoneum. The removal of such cysts—if possible without rupture—is imperatively demanded.

#### HYDROPS FOLLICULI.

O. v. FRANQUÉ, Würzburg (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 2) describes a specimen taken from a well-nourished child which died eighteen hours after birth at term. There was a cyst of the left ovary the size of a pigeon's egg, with a pedicle twisted three times round. The microscopic examination showed that the cyst was derived from a Graafian follicle.

#### OVARIAN CYSTOMATA COMPLICATING PREGNANCY: THEIR DIAGNOSIS AND TREATMENT.

FEHLING, Halle (72 Congress, *Nat. u. Aerzte*, Sept. 17, 1900), pointed out that while the diagnosis of small tumours is generally easy, it may be difficult or even impossible in the case of large relaxed cysts covering the uterus, inasmuch as hydramnios and ascites cannot always be excluded. He illustrated this difficulty by three cases selected from a number of similar observations as being particularly instructive. In cases of very great difficulty he recommended exploratory puncture from the abdominal side. The determination by this means of pseudo mucin—a characteristic of ovarian cysts—assures their diagnosis.

As regards treatment in pregnancy, laparotomy is recommended by all authorities. The mortality is merely the same, 5.4 per cent., which is the average for all ovariectomies. But the loss of children is about 33 per cent. Statistics also show that the danger of interrupting pregnancy increases with every month. It is therefore improper to recommend laparotomy so absolutely; when there is incarceration, torsion of the pedicle, inflammation, or rapid and dangerous enlargement,



one should operate, but otherwise one should, in the interest of the child, wait. The abdominal way should be chosen, as the pulling about of the uterus in the vaginal operation increases the danger of abortion.

SCHATZ (Rostock) in a case in which rupture of the uterus necessitated laparotomy, found Douglas' pouch filled by a parovarian cyst with strong walls, and as big as a child's head. For such cases of incarceration of an ovarian or parovarian cyst during pregnancy or labour, when reposition had proved impossible, he thought puncture from the vagina a simple and efficacious mode of treatment, and free from danger.

### SALPINGITIS AND ITS TREATMENT.

PERRIER (*Thèse de Paris*, 494, 1900) insists that intra-uterine treatment may not merely amend but cure salpingitis. Dilatation combined with intra-uterine irrigation and drainage is a means not only most efficacious, but less dangerous than others, and ought to be tried, before any surgical intervention, not only in catarrhal but in purulent and cystic salpingitis. It is contra-indicated in tubercular and syphilitic affections, in those accompanied by marked lesions of the ovaries, and in very adherent or very voluminous affections of the tubes—and, moreover, when the patient is in immediate danger of fever, impending peritonitis, or aggravations of previous peritonitis. In all such cases immediate surgical intervention is required.

ROUFFART (*Bull. Soc. Belge de Gyn., &c.*, No. 10, 1900) reports the following case. A woman, aged 27, nineteen months after her fourth labour, which, like all the others, had been very difficult, was obliged to keep her bed because of recurring crises of pain in her left hypogastrium; these pains soon became continuous.

The cervix was found lacerated and enlarged, with a gaping os; the corpus uteri enlarged and retroverted. To the front and left of the uterus was a tumour the size of an orange; to the right an enlarged tube. On opening the abdomen a brownish mass was seen immediately behind the bladder, like an engorged loop of intestine. This mass was fluctuating and adherent behind to the rectum and the lower part of the sigmoid flexure; it completely hid the corpus uteri; in detaching it from the rectum some pus escaped, but was at once dried up. When it had been separated from the intestine and the anterior face of the uterus, the latter was easily brought forward, and the right tube detached from its intestinal adhesions. The uterus and tubes were then extirpated, and a drain having been passed through the stump of the cervix, the peritoneum was closed. As there was some oozing from the torn surface of the rectum

the pouch of Douglas was opened, lightly plugged from the vagina, and shut off by uniting the vesical peritoneum to the intestinal. On the eighth day the temperature rose to 40° C., as the drainage had become occluded; a double-barrelled drain was inserted, and convalescence was not again interrupted. The specimen showed that the tube had been twisted, the pavilion turned towards the middle line, and the ostium closed, partly by the anterior face of the retroverted womb partly, higher up, by that of the rectum.

From October, 1898, to May, 1900, CERNÉ performed twenty-eight laparotomies for salpingo-oöphoritis, in seven instances only removing the tubes. In nine of the remaining twenty-one cases in which the tubes were preserved the disease was not serious, but in the other twelve the tubes were enlarged and adherent and transformed into cystic bodies; there was pyosalpinx in seven cases. One woman died, and the tubes which had not been removed, contained pus. The immediate and after results in the remaining cases were very good.—(*Lucina*, Agosto, 1900.)

F. E.

#### DERMOID CYSTOMA OF THE PELVIC CONNECTIVE TISSUE.

By H. D. BEYEA. *Amer. Jour. Obstet.*, April, 1900.

The pelvic connective tissue here referred to, lies above the pelvic diaphragm, *i.e.*, above the levator ani, and beneath the peritoneum. The tissue enclosed in the meso-salpinx is excluded. The patient, aged 38, had had both appendages removed for inflammatory disease twelve years ago, and had enjoyed very good health until six weeks before coming under observation last November, when she began to complain of backache, pain and tenderness in the right ovarian region. Above Poupart's ligament, on the right side, and extending to a point midway between the pubes and umbilicus, there was an area of resistance which was dull on percussion. The atrophic changes in the pelvis were quite characteristic of the complete climacterium, and bulging into the right vaginal vault, and displacing the small atrophic uterus upwards and to the left, there was a rather tender cystic tumour, which was part of the mass protruding above Poupart's ligament. Since both appendages had been removed it was difficult even to guess at the character of the tumour. Upon abdominal section the uterus was found to be displaced by a cystoma the size of a large grape fruit, growing deeply in the pelvic cavity and completely separating the peritoneal layers of the right broad ligament. There were no traces of any ovarian tissue and no adhesions. The cystoma was enucleated, and except at the uterus, where

the utero-ovarian vessels were injured, the bleeding was not profuse. Several attempts to control this bleeding by ligature having failed, the uterus was removed. The tumour proved to be a dermoid cyst, the walls lined by stratified squamous epithelium, and the contents sebaceous material, mucus, undeveloped teeth, hair and fat and connective tissue. The clinical history of the case, the anatomical conditions present and the pathological report, all tend to show that the cystoma had not developed from any pre-existing ovarian tissue. A *résumé* of twenty-two similar cases which the author has found in the literature of the subject is annexed.

J. F. J.

#### SUPPURATING CYST OF RIGHT BROAD LIGAMENT.

MUNRO KERR (*Glasgow Med. Journ.*, July, 1900) records a case of sepsis following abdominal section, and fatal on the fifth day after operation, in which there was entire absence of all local symptoms. The patient's temperature, usually much below, only once exceeded  $99.8^{\circ}$ . It then registered  $100.2^{\circ}$ . Her tongue was moist and fairly clean. Her pulse, which rose from  $95^{\circ}$  to  $116^{\circ}$  on the third day, and an exaggerated feeling of well being, which persisted to the end, alone indicated the gravity of her condition. The patient, aged 35, had been confined for the third time a year previously, and had then had puerperal fever. On admission to infirmary she was collapsed. Munro Kerr removed a large suppurating cyst of the right broad ligament, in which the pedicle had become twisted, apparently from the recent nature of the adhesions during the woman's removal to infirmary.

During the operation a small quantity of odourless pus escaped into the abdominal cavity. Professor Muir examined a portion and found only the streptococcus pyogenes present.

The conclusion drawn was, that an old broad ligament cyst had become infected during the last puerperium.

J. M. M.-J.

#### ON THE RELATIVE VALUE OF SYMPTOMS OF ACUTE PERITONITIS.

By E. STANMORE BISHOP. *The Lancet*, June 9, 1900.

The author points out the great advantage of being able to say definitely in any case whether peritonitis is or is not present, and quoting from many standard authorities—Spence, Heath, Treves, Senn, and Jakob—shows that, as described by them, the symptoms of peritonitis are so variable and indefinite, and so uncertain in degree and existence, as to be practically useless for diagnostic purposes. The symptoms common to all the descriptions are: sudden and continuous pain; tenderness; hot dry skin; temperature elevated, normal or depressed; hard "wiry"



pulse; quickened respiration; tympanites; clear note on percussion unless effusion has occurred, when there is dulness in the flanks; distended abdomen; altered facial expression; flexed thighs and characteristic position of the body; and, later, vomiting.

The facies is perhaps the only characteristic feature, but it comes rather late for diagnostic purposes. Pain cannot be judged. Tenderness is a vague symptom. Hot skin means nothing. "Wiry" pulse is difficult to judge, and is not characteristic nor constant. Tympanites and distended abdomen are inconstant and late symptoms. Vomiting is late and of varied origin. Flexion of the extremities occurs in colics. The one symptom Bishop claims as constant and pathognomonic is rigidity of the abdominal muscles. He explains this as reflex muscular action occurring in the same way as that in the muscles about a joint when there is inflammation of that joint. Kelynack has called the neuro-muscular mechanism in such cases a "visceral joint." A warm hand, gentleness, patience and sympathy are necessary to diagnose the condition correctly, and Bishop gives three cases where the symptom enabled him in each case to judge rightly whether to operate or not.

Treves lays stress on "abdominal respiration ceasing in peritonitis," but it is well to study carefully each and every sign, and it is only by training the mind to note and reason on each and all the symptoms that a fair and just conclusion will be arrived at. Certain symptoms will be the more valuable criteria to some surgeons, and other symptoms to other surgeons, since the perceptive and reasoning faculties differ in each person.

F. E.

#### POST-OPERATIVE ILEUS AND ITS OPERATIVE TREATMENT.

WINTERNITZ, Tübingen (72 Congress N. u. Aerzte, Sept. 17, 1900), said that the chief conditions that, without any fault of the operator, may supervene after abdominal operations and endanger or destroy their good effects are pulmonary emboli and ileus. Of the latter he distinguished four forms (1) septic ileus, the result of a septic peritonitis; (2) mechanical non-septic ileus, generally due to intestinal adhesions with consequent kinking or axial torsion; (3) paralytic ileus; and (4) ileus such as is seen after total extirpation with the use of clamps, though no adhesions or injury of the intestines by pressure is to be found.

In Doederlein's clinic during the last three years, among 837 intra-peritoneal operations (459 laparotomies, 280 vaginal total extirpations and 78 colpo-cœliotomies), there were 11 instances of post-operative ileus, 5 of which were after vaginal operations; ætiologically 3 were septic, 7 mechanical non-septic,



and 1 paralytic. A second operation did not save any of the septic cases, but was successful in 6 of the 7 mechanical ones.

Freund believes it possible by careful observation of the patients from the very first day after operation, to make, in many cases, a differential diagnosis between septic and mechanical non-septic ileus. Peritonitis generally makes its onset very soon after the operation, while mechanical ileus has, in time, no definite connection thereto.

Fever points to peritonitis, the occurrence of which without fever is exceptional. In mechanical ileus, while the pulse increases in frequency there is no rise in temperature. In septic cases the abdomen is uniformly distended and everywhere tender; in mechanical the meteorism as a rule is localised; one can see and feel the contractions of the blown out intestine and they are accompanied by severe pains and local noises.

If the case be diagnosed as one of mechanical ileus, the abdomen must be reopened. It is not, however, always easy to decide on the exact moment for intervention. The following rules are accepted in Doederlein's service. If no flatus be passed and the symptoms of ileus set in (*i.e.*, hiccough and vomiting of greenish matter with a fæculent smell), high injections repeated several times in the day, washing out the stomach and massage, are first tried; if the symptoms persist and there is meteorism with lowering of the temperature and quickening of the pulse, operation is undertaken. The most important points in the surgical treatment of mechanical non-septic ileus are, as Winternitz states them:—

(1) After vaginal operations, an attempt must first be made *per vaginam* to separate any adhesions that may have formed; should this fail, laparotomy must be performed.

(2) After abdominal operations, the abdomen must be reopened, and after the separation of adhesions it is of the greatest importance that every distended portion of the bowel should be emptied. This is to be done by stroking out the contents; the use of gloves is desirable.

(3) The same method may be tried, and be successful in paralytic cases.

(4) Operative treatment is useless in septic ileus, and is therefore contra-indicated.

#### THE ETIOLOGY OF EXTRAUTERINE PREGNANCY.

E. PESTALOZZA (*Lucina*, Agosto, 1900) recently operated in a case where abortion had taken place and the fœtus was found with its cephalic extremity upon the pavilion of the tube. The corpus luteum was situated in the ovary of the opposite side. Having conclusively convinced himself that the ovum had

migrated from the opposite side, the question occurred to him whether such a coincidence as the external migration of the ovum, which others besides himself had had the opportunities of observing, may not really be one of the true causes of ectopic development.

The authenticated cases of external migration in tubal pregnancy are too numerous to be accepted as merely coincidences. Continued observation alone can settle the matter, but cases are now so frequent that we may hope it will be shortly decided. Pestalozza operated upon forty-eight in a little over six years.

F. E.

GEITSCH (*Achiv. f. Gyn. Bd., lx., Heft 3*), from the study of forty-three cases in the Midwifery Institution at Stuttgart, concludes: Predisposition may be congenital or acquired, but the most important factor in the etiology of tubal gestation is inflammation in the tube itself or in its neighbourhood, compared with which such causes as foetal kinking, polypi and tumours, are exceptionally rare. The excitants of such inflammation are streptococci, bacilli tuberculosis, but especially gonococci. In his opinion an active or past gonorrhœa of the tubes may be traced in the majority of cases of ectopic pregnancy.

#### THE PATHOLOGY OF TUBAL PREGNANCY. A SUMMARY OF THE STUDY OF FORTY CASES.

By MAXIMILIAN HERZOG. *Amer. Journ. Obst.*, August, 1900.

The author discards inflammatory diseases of the uterus and tubes as a cause of tubal pregnancy. The factors which he considers of most importance are congenital anomalies of the tubes and an unduly marked participation of the tubal mucosa in menstruation. The tubal mucosa may undergo such pronounced menstrual changes as to lead to the formation of a hæmatosalpinx and, just as the menstrual changes in the uterine mucosa prepare the latter for the reception of the impregnated ovum, so may those in the tubal mucosa prepare it for a similar function. Henkelom and Peters have shown that the human ovum soon after fecundation is surrounded by a layer of solid ectoblasts, called trophoblast. This trophoblast has phagocytic properties, and enables the ovum to corrode or eat its way into the uterine mucosa, which has already assumed the character of a decidua. Since this is the normal *modus operandi in utero* it is easy to understand how the phagocytic trophoblast would facilitate the retention of the fecundated ovum in a tube the mucosa of which had undergone menstrual changes.

The early foetal placenta of tubal pregnancy does not differ from one of the same age in uterine gestation. With silvered surface preparations the amnion is seen to resemble the serous

membranes, and its internal lining would better be called endothelial than epithelial. The chorion and its villi show a mesodermal core covered by the two epithelial cell layers, the layer of Langhans internally and the syncytium externally—this latter consisting of plasmodium in which numerous nuclei but no cell boundaries can be seen. The syncytium is of foetal origin; it comes neither from the maternal decidua structures nor from a proliferation of maternal vascular endothelium; in tubal pregnancy it forms the same kind of syncytial buds that have been described in uterine placenta. The blood in the vessels of the chorion and villi is of course foetal blood containing nucleated red blood corpuscles and no leucocytes. The blood in the intervillous spaces is maternal, containing the ordinary non-nucleated red blood corpuscles and the due proportion of leucocytes.

A decidua serotina is most certainly formed in tubal pregnancy. Under the stimulus of the developing ovum in the tube the cells of the connective tissue of the mucosa become enlarged, and opposite the site of the ovum cells are found of the same character as the decidua cells in the uterine serotina—large oval or polygonal, with large round or oval vesicular nuclei. The enlarged vessels in the tubal plicae become surrounded by cells decidua in their character. Neighbouring club-shaped plicae become fused at their extremities and so there is produced an upper compact and a lower spongy layer. This arrangement is seen in a few cases only, pathological changes occurring so early that the original condition is soon obscured. The earliest pathological changes occur in the tubal structures lying outside the mucosa. There may be hypertrophy of the muscle fibres but not, as a rule, commensurate with the age of the ovum. There may be atrophy, the bundles of fibres being pushed apart and the interstices between them, either filled with loose connective tissue and leucocytes, or with an oedematous infiltration with leucocytes. An oedematous infiltration of the muscular and sub-peritoneal layers of the tube wall soon follows, accompanied by the presence of polynuclear leucocytes.

The opening up of the maternal blood sinuses by the syncytium and the proliferating Langhans cells is enormously exaggerated in tubal pregnancy, and this it is that causes hæmorrhage into the tube wall and the intervillous hæmorrhages, so that in addition to oedema of the muscular and sub-peritoneal layers of the tube wall we get free blood in these tissues. The hæmorrhage is therefore due to the penetrative destructive action of the placental foetal ectoderm, which action in tubal pregnancy is greatly favoured by the oedematous infiltration of the tube wall and by the thinness of the decidua with its comparatively extensive blood sinuses. No pressure, resembling that of the



uterus, is exerted by the tube wall to prohibit the proliferation of the foetal ectoderm. The hæmorrhages from the decidua into the intervillous spaces cause the death of the embryo by damaging the villi and thus interfering with its nutrition. Rupture or abortion follow after the death of the embryo. Recognition of these facts is of importance. If it should be possible to establish a set of symptoms as characteristic for intervillous hæmorrhages, the operator might step in in good time to save his patient from the dangers of subsequent rupture.

J. F. J.

RALLI (*Thèse de Paris*, 1900, No. 465). Extra-uterine pregnancy should be thought of whenever a woman, after suspension of her catamenia, suffers from localised abdominal pain. It is sometimes impossible to form a diagnosis at first, examination must be repeated. In all cases one meets with variable troubles, especially at first—pains, bleedings, general disturbances, and vesical and rectal symptoms.

Hysteroscopy will exclude ordinary bleeding from the uterine mucosa. Catamenia suppressed during ectopic gestation reappear two months after death of the foetus. Generally there is on expulsion of the caduca—even if there be, the foetus may continue to live and develop. The foetal sac after the death of the foetus is subjected at the time of the reappearance to a tension which is prolonged, and returns with each menstruation. The sac in far the greater number of cases is immovable in the abdominal cavity. Superficiality of the foetal parts is quite exceptional. Digital exploration of the uterine cavity ought always to be tried, *s.o.s.* under anæsthesia. After the six months the woman, if the child be alive, should be under direct and rigorous observation, with a view to laparotomy after the eighth month and before term—at term or false labour the child dies. As Pinard says, "every extra-uterine pregnancy diagnosed necessitates surgical intervention."

#### ECTOPIC PREGNANCY AND MYOMA.

MEEK (*Amer. Jour. Obstet.*, May, 1900) relates the following case: The patient, aged 33, had been married nine years, had one child aged 18 months. Menstruation, as a rule, regular, but a little too profuse. Last period, October 13, 1898, she felt very well till one morning in the first week in January, 1899, when she awoke with severe pain in epigastrium and sternal region, accompanied by slight faintness. This attack passed off in two hours. Two weeks later, on January 17, she had a similar attack but it persisted, and on the next day the pain became localised in and above iliac region on the right side. There was a little vomiting; loss of appetite; bowels moved by



purgatives; temperature  $99.8^{\circ}$  and pulse  $90^{\circ}$ . When seen at this time she was not anæmic nor did she look ill. Examination was difficult, on account of her great stoutness. An enlargement and thickening could be indistinctly felt in the right iliac and lumbar regions, and another in the middle, reaching nearly to the umbilicus. On bimanual examination, the fundus could be felt high up in front; behind and to the right was a hard mass in the uterine wall, evidently a myoma. The whole uterine tumour was mobile and as regards its outline was distinct from the mass on the right side. The patient was kept quiet and under observation; she lost weight rapidly, the mass on the right side became larger, while the uterine tumour appeared to remain stationary. About the middle of March there was little watery vaginal discharge followed by some painful uterine contractions. On April 7 she was again examined, the mass on the right side felt "something like an enlarged pregnant uterus, but the location and shape were more like a tumour of the right kidney." The uterine tumour same as before; a bruit like that of normal pregnancy could be heard just above the pubes, but no foetal movements could be felt nor could the foetal heart be heard. On May 3, examination under anæsthesia: "The abdominal tumour had the characters of a tumour of the right kidney, and a distinct sulcus could be felt between its lower end and the upper right cornu of the uterine tumour. The two tumours were, however, connected at this point by what appeared to be inflammatory adhesion bands. Sound passed into uterus between six and seven inches." The uterus was curetted and a large quantity of thickened decidua removed. The bleeding was profuse. On the fifth day after curettage the temperature went up to  $102^{\circ}$  F., and pulse over 120. Nausea, vomiting, bearing down pain, pain on passing urine, which contained pus. The myoma became hot and tender; abdominal tumour not so. These symptoms lasted nearly two weeks and then subsided. The scrapings from the curettage consisted of normal decidua. By May 31 the uterus had considerably diminished in size, the myoma and the abdominal tumour were both a little smaller.

On June 15, an exploratory incision was made in the right semilunar line. The surface of the tumour was adherent to the parietal peritoneum and in enucleating the outer part the sac wall was broken through; it was then found to contain a foetus. The placenta lay to the inner side and in front of the foetus, and was attached to the peritoneum on the outer side of the ascending colon. The whole sac lay in a bed directly in front of the right kidney, having pushed the colon over near the median line of the abdomen. The lower, smaller end, was in the right iliac fossa. Attached to this end and to the abdominal peritoneum at this point, was the fimbriated end of the right Fallopian

tube. The abdominal end of the tube was separated and ligatured and the whole sac, containing foetus and placenta, was then readily enucleated from its bed and removed. Convalescence was uneventful. In commenting upon the case the author says "It is probable that a tubal abortion, with expulsion of sac and contents complete into abdominal cavity, took place in the first week in January. The position of the tube would be raised owing to the myoma, and the abortion took place into the space outside the cæcum and there formed attachments. Development as an abdominal pregnancy continued till the foetus died, about April 1, when there were some false labour pains, and later on some diminution in size of the abdominal tumour.

The difficulties in making a correct diagnosis before operation were: "The absence of marked symptoms of internal hæmorrhage at any time; the fat abdominal wall; the inability to detect either foetal movement or foetal heart; and the enlarged myomatous uterus having about it all the early signs of intra-uterine pregnancy complicated by myoma."

J. F. J.

#### EXTRA-UTERINE PREGNANCY: PERFORATION INTO THE BLADDER.

BAATZ (*Inaug. Diss. Koenigsberg*, 1899) relates a very interesting case of perforation of the bladder due to extra-uterine pregnancy. With the catheter, a number of bone-like masses could be felt in the bladder, while close to the right of the uterus lay a crepitating tumour as large as a child's head. Cystoscopy disclosed the presence of bones in the bladder; illumination with the Roentgen rays gave no information. The urethra was dilated and several calcified bones extracted; the foetal sac was incised by the para-vaginal way without opening the peritoneum, and numerous calcified bones and much thickened pus was removed; the cavity was washed out with lysol and a drain inserted. One piece of bone was spontaneously discharged from the bladder, and a month later five others were extracted after the urethra had been again dilated. Slight incontinence of urine remained some time after recovery. Similar published cases (thirteen) are quoted.

#### PREGNANCY AND CONFINEMENT AFTER BILATERAL CASTRATION.

KOSSMAN (*Münch. med. Wchns.*, 1900, S. 313) can only explain the conception by the supposition that the ligatures of catgut, applied before the extirpation, though they sufficed to prevent hæmorrhage, did not cut off the nourishment of some small remnant of ovarian tissue remaining outside them. He is satisfied that he did not overlook any superfluous ovary.

## SUPERFÆTATION.

WOLFF (*Archiv. f. Gyn.*, Bd. lx., S. 291) describes a *post-mortem* specimen. A uterus pregnant in the fifth month contained two male fœtus, unequal in size, each with its chorion and independent placenta. In the left ovary were two corpora lutea of somewhat unequal size, with unequal central blood effusions, and therefore in different stages of development. He concludes, not without reason, that the case was one of superfætation, the second ovum having been fertilised and implanted into the uterus several weeks after normal conception.

## THE RAPID INDUCTION OF ABORTION.

DOLÉRIS (*Sem. Méd.*, September 5, 1900) writes strongly in favour of the induction of abortion at one sitting (*l'avortement brusqué*) in cases where that operation is necessary. The advantages which he claims are:—

The performance of the operation can be timed exactly by circumstances, it is rapidly executed, there is but little loss of blood, the uterine cavity is completely evacuated with no possibility of the partial retention of the ovum, and both pre-operative and post-operative asepsis are secure. Dilatation is performed by means of Hegar's dilators, preceded if necessary by laminaria tents. The uterus is emptied by means of a special fenestrated forceps which Doléris has devised, and the cavity is then curetted with a *large* curette.

H. J.

## INDUCTION OF ABORTION BY THE INTRA-UTERINE INJECTION OF IODINE.

OEHLSCHLÄGER, Dantzig (*Sem. Méd.*, July 11, 1900), states that the best method of inducing abortion consists in injecting into the uterus three or four grammes of pure tincture of iodine, by means of a metal canula, the nozzle of which must be passed right up to the fundus. The vagina is plugged with aseptic cotton wool, to save its mucous membrane from the effects of the iodine as it escapes from the cervix. The result of this operation is a bloody discharge that usually appears about the third day, has all the characters of the menstrual flow, and brings with it the ovum. In case of failure, which only occurs when the canula has not been passed completely up to the fundus, the operation is repeated; it is quite free from danger, in consequence of the eminently antiseptic properties of the fluid injected.

H. J.

## ABORTION. DIACHYLON AS AN ABORTIFACIENT.

RANSOM (*B. M. J.*, June 30, 1900) points out the impropriety of the free sale of preparations of lead by druggists. Such



preparations are purchased and taken by women to induce abortion, and frequently fulfil that purpose, with disastrous effects on the brain and nervous system. Of three cases of encephalopathia saturnina he here records two were caused by this practice.

#### ACETONURIA IN PREGNANCY, LABOUR AND CHILD-BED.

ROUSSE (*Annales de Gyn. et d'Obs.*, March, 1900), has convinced himself, by Lieben's test in numerous cases, that aceton is present to the same extent, under normal circumstances, as when there is a macerated foetus. During labour the amount of aceton in the urine increases, and during the first days of puerpery it remains high, after which it falls. Aceton was also found in the liquor amnii.

The test is: To 10 ccm. urine are added a few drops of Lugol's solution (*Liquor Iodi.*, B.P., 1885) and then caustic soda, till the brown colour disappears. The presence of aceton causes a white precipitate of iodoform.

#### THE TOXÆMIA OF PREGNANCY. By EGBERT H. GRANDIN. *Amer. Jour. Obstet.*, June, 1900.

Speaking from an experience of cases of eclampsia extending over twenty years, the author thinks it a grave error to test the urine of a gravid woman for albumin alone. The mere presence or absence of albumin means nothing. From an analysis of his cases he finds that, as a rule, toxemia is least likely to occur in those subjects in whom albumin in moderate amount exists, while virulent toxæmia frequently occurs in subjects in whose urine albumin is absent, or present in trifling amount only. "No man's duty, therefore, can be considered as complete unless, at regular intervals, the amount of urine passed in twenty-four hours is measured and an accurate estimate of the amount of urea is obtained from this total amount, taking into rigid account the customary diet of the woman and the amount of fluid she ingests." If a woman, subject to nephritis, conceives, she must be very carefully watched, and if in spite of prophylactic measures the urea diminishes, and also the amount of urine secreted, the question of terminating the pregnancy must be seriously considered. "In cases where albumin does not exist, or only in traces, and yet there is determined a steady decrease in the amount of urea excreted, expectancy may be fatal. The positive rule should be the evacuation of the uterus as speedily as may be." In cases in which eclampsia is imminent or present the sheet anchors of treatment, according to the author, should be rapid evacuation of the uterus, venesection and protracted irrigation of the colon with hot saline solution. Morphia is contra-indicated; veratrum



is useless, arterial tension being better lowered by means of large doses of nitro-glycerine ( $\frac{1}{10}$  gr. hypodermically) and by venesection. Several interesting cases are reported which "testify to the great aid toward securing the proper therapeusis yielded by the systematic examination of the urine for urea, instead of trusting to the presence or absence of albumin." He concludes: "The only justifiable treatment of toxæmia is the surgical before the active manifestations set in. In the presence of these premonitory symptoms I have seen the opium treatment tested, and it has failed. I have seen the administration of veratrum until the pulse rate was held at forty, and it too has failed. I have seen the eliminative treatment instituted after the development of active toxæmia, and it has failed." One course of action remains; allow the gestation to continue as long as the amount of urea remains at the normal. If, under dietetic measures, the urea drops below the normal, the uterus must be emptied. Where time permits, the packing of the cervical canal with gauze is the step precedent to the manual evacuation of the uterus. In the face of the symptoms of active toxæmia the uterus may, as a rule, be emptied within thirty minutes. Temporising in these cases will nearly always eventuate in active toxæmia, when interference of any nature will be useless. (For Eclampsia v. Paris Congress, *supra* p. 112.)

J. F. J.

#### PLASTIC OPERATIONS ON THE VULVA AND VAGINA IN RELATION TO CHILDBEARING.

MOMBET (*Thèse de Paris*, No. 466, 1900), reviewing the methods of Doléris to restore vulva, vagina, and perineum to their normal form and proportion, says that such operations are not only demanded to remedy disease or displacement of the genital organs, but are also often useful by preventing a precipitate and promoting a normal labour. Dystocia caused by a vaginal operation, such as colpoperineorrhaphy in particular, is due to faulty methods or post-operative complications, among which infection and suppuration are particularly to be feared, since they result in hard cicatricial tissue which, by its inextensibility, may form an obstacle to the passage of the foetal head. Perfect asepsis, especially before operation, the use of the constant current, sutures of thick flat silk, and post-operative care will ward off such accidents. In attending a woman in labour who has undergone a well-conducted operation upon her vagina and perineum, one should remember that such operation, far from creating an impediment to the expulsion of the foetus, has re-established the symmetry of the muscular planes involved in the normal mechanism of delivery, and should therefore avoid premature or hurried intervention.

## THE SIGNIFICANCE OF DISCHARGE OF MECONIUM.

KOSSMANN, Berlin (*Münch. med. Wchns.*, 1900, S. 313), in a head presentation noticed the outflow of meconium during a whole day while the heart sounds remained normal, and insists on the importance of observing the heart sounds, concluding from this case that the discharge of meconium is no indication for operative interference.

## OBSTETRICAL ANÆSTHESIA BY MEANS OF INJECTION OF COCAINE UNDER THE LUMBAR ARACHNOID.

DOLÉRIS and MALARTIC (*Sem. Méd.*, July 18, 1900) record five cases of parturient women in whom the use of general anæsthesia was replaced by the injection of cocaine into the arachnoid cavity of the lumbar spine.

From five to ten minutes after the injection of from 1 to 2 c. grms. of cocaine, the pain caused by the uterine contractions ceased, and the analgesia thus obtained lasted from an hour and a half to two hours. The contractions were more energetic more frequent, and longer, after the injections, and between them the uterus remained in a state of semi-tension for a varying time. It would therefore seem prudent, until more full information on the subject is available, not to adopt cocaine anæsthesia in cases in which podalic version may be afterwards required. The loss of blood appeared to be less than usual; in no case had the injections any effect on the fœtus.

BUMM of Bâle, and his assistant KREIS (*loc. cit.*) have also experimented with cocaine in six parturients, five of whom were primiparæ. In these cases after dilatation of the cervix was complete, 1 c. grm. of chlorhydrate of cocaine was injected according to the method described recently by Tuffier of Paris (*Sem. Méd.*, 1900, p. 167). At the end of five or ten minutes there was an absolute analgesia of the lower portion of the body, extending as far as the edge of the ribs. Tactile sensation was lessened, but voluntary movements were unimpaired. Uterine contractions were as frequent and as intense as before, but were quite painless, causing only a sense of tension in the abdomen. The patients had complete control of the power of "bearing down," and also of the inclination to do so. The pressure of the fœtal head on the pelvic floor did not give rise to any pain.

In two cases delivery was spontaneous, and there was no pain as the head passed over the perinæum. Twice forceps were applied, and once the after-coming head had to be extracted. In no case was there any suffering. Similarly, the suture of the perinæum was unattended by pain. The expulsion of the secundines was normal in all cases.

The use of the cocaine caused no serious trouble in any

of the cases; two patients suffered from headache with slight vertigo and vomiting. H. J.

THE USE OF THE INTRA-UTERINE BAG IN CASES OF PREMATURE RUPTURE OF THE MEMBRANES.

RUBESKA, of Prague (*Sem. Méd.*, July 25, 1900), has found the intra-uterine hydrostatic dilator to be an excellent substitute for the membranes in cases of premature rupture of the latter, especially so when the premature rupture has been due to a contracted pelvis. H. J.

SUPERFICIAL EMPHYSEMA OCCURRING DURING LABOUR.

By BARR STEPHENS (*Glasgow Med. Jour.*, August, 1900).

While attending a I.-para, aged 20, at full term, in the sixteenth hour of labour, twice heard a small clicking sound resembling that produced by squeezing in part of a felt hat and allowing it to spring out again. It occurred during the acme of a pain, and while the patient was straining to the utmost. Suddenly the nurse directed attention to the swollen condition of the patient's face. The swelling—which by crepitation and pitting on pressure was readily recognisable as surgical emphysema—reached the top of the crests of the scapula behind, slightly affected the breasts in front, and extended a short distance down the right arm. Stevens administered chloroform and delivered the patient of a female child weighing over ten pounds. There was pain at both shoulders, the sternum, and left side of the neck. There was no evidence of fracture. Displacements of the viscera, symptoms of pneumothorax, and hæmoptysis were entirely absent. For four days there was slight pain on swallowing. The temperature remained normal. On the fifth day very little trace of emphysema remained, and on the seventh it had disappeared.

Various opinions upon the pathology of the condition are quoted:—

(1) Burton, who believed there was rupture into the posterior mediastinum, and consequent passage of air into the loose areolar tissue round the œsophagus.

(2) Worthington, who held that rupture of the upper part of the lung took place.

(3) Champneys, who maintained that air escaped near the root of the lung, and passed beneath the pulmonary pleura into the anterior mediastinum and so beneath the deep cervical fascia into the neck; actual rupture occurring in the fissure between the lobes and spaces between the lobules.

(4) Scheffelaar Klots, who is of opinion that superficial emphysema occurs as a result of an interstitial secondary to a

vesicular emphysema. From an analysis of forty recorded cases Klots infers that neither lung affection nor predisposition are necessary antecedents; that emphysema is frequently overlooked; that where diagnosed it has not been understood, and that many cases have not been published. Champneys opined that such emphysema occur once in every two thousand labours.

H. M. M.-J.

#### SYMPHYSEOTOMY.

FRANK, Cologne (72 *Cong. f. N. v. Aerzte*, September 18, 1900) claimed a permanent place for symphyseotomy among obstetric operations, while admitting that its value had been over-estimated and that suitable cases must be carefully selected. To the specialist the operation offered no difficulty: the symphysis is easily found and divided, or, if actually ossified, a few strokes of the chisel are all that is required. The dangers lie not in the division of the bony ring but in the injuries during labour of the soft parts to which that ring, while undivided, gave support and protection. The danger of serious hæmorrhage is greater from lacerations in front than from those behind; moreover, since the wounds are hard to keep clean the torn venous plexus are a dangerous source for pyæmia. One must, therefore, try to make the risk as small and the advantage as great as possible. The risk is small when the soft parts are relaxed, the vagina capacious, the os uteri dilated, the pelvis not too narrow, and the patient strong and with little fatty tissue. The advantage is great in multiparæ, in whom previous labours have shown that neither prophylactic version nor forceps has availed; and when it seems probable that on this, as on former occasions, the child would be born dead, though the mother longs for a living one; and when Cæsarean section—the labour being so far advanced, no longer without danger—is declined. Every case must be treated on its own merits, and every possible mischance must be reckoned with. In the after-treatment minutest cleanliness is essential. Frank undertakes no osteoplastic measures to correct the deficient pelvis. He considers simple division of the symphysis enough. It is unnecessary to aim at solid union; suture of the bones is superfluous. In every case he was able to follow up, perfect capacity for work was recovered, and he has seen instances of difficult forceps extraction, without any symphyseotomy, followed by such severe sacral periostitis as to incapacitate the woman from any hard work for years.

SYMPHYSEOTOMY IN ILLINOIS. By G. N. KREIDER.  
*Amer. Jour. Obstet.*, July, 1900.

The author believes that symphysetomy has a place, though somewhat limited, in obstetric surgery. It may best be



regarded as an adjuvant to delivery by the axis traction forceps, and should be employed where forceps delivery in the Walcher position is impossible, and where there is no doubt that the increased pelvic measurements resulting from the operation will allow the head to be extracted. He quotes from several operators in Illinois who express approval of the operation, and that too as a result of their own personal experience. The method of operating he describes briefly as follows: "A free incision is made over the symphysis, terminating a little above the clitoris, and the retro-pubic tissues are pushed carefully away. When the bone is reached the finger should be introduced posteriorly between the recti muscles into the *cavum Retzii*, and the bladder and peritoneum should be thoroughly separated from the entire posterior surface of the symphysis well down to the arch. As the bones are more widely separated in the front, it will be found easier to open the joint from before backwards with an ordinary scalpel. The symphysis should always be completely divided until the ends of the bones are held together only by *ligamentum arcuatum* and the deep perineal fascia, or so-called triangular ligament. These structures should now be carefully separated from the arch of the pubis by a blunt-pointed bistoury under guidance of the finger, closely hugging the bone on each side. As fast as the tense fibres are divided from the arch it will be seen that the space at the symphysis gradually widens. If the ligament and fascia are carefully detached laterally from the bone all danger of hæmorrhage and laceration of the soft parts will be avoided.

J. F. J.

#### CÆSAREAN SECTION AND PORRO'S OPERATION.

By CHARLES B. REED. *Amer. Jour. Obstet.*, July, 1900.

Surgical art has so far advanced in the last few years that these operations are no longer competitors, but rather one supplements the other.

The indications in each case are definite; for Cæsarean section they are "absolute" when there is no alternative and delivery cannot be effected otherwise, and "relative" when there is a choice between this and other procedures. The absolute indications are: (1) Contracted pelvis—flat pelvis with *conjugata vera*  $2\frac{1}{2}$  inches and child living; generally contracted pelvis  $2\frac{3}{4}$  to 3 inches; or pelvis with *conjugata vera*  $2\frac{1}{2}$  inches and child dead. (2) Presence of large bony growths (*exostoses*) in the pelvis. (3) Extreme atresia of lower genital tract, either congenital or acquired. (4) The occurrence of a grave accident in labour, as rupture of the uterus or sudden death of the mother. (5) Carcinomatous degeneration of cervix or vagina.

Cæsarean section competes with symphyseotomy when the

child is alive and the conjugata vera varies from  $2\frac{1}{2}$  to 3 inches. Craniotomy must be chosen in all cases where the child is dead and the conjugata vera of the pelvis will permit the delivery of the mutilated child.

The prognosis depends chiefly upon the condition of the mother at the time of operation, but is subject to many other influences. Gonorrhœal infection has an unfavourable influence on the subsequent course of a Cæsarean section, and therefore in these cases craniotomy or Porro's operation is advised. Maintenance of complete asepsis is of the greatest importance. The most desirable time to perform the operation is at term or when the labour pains begin.

Porro's operation is indicated (1) in all cases where, owing to the general conditions, Cæsarean section is indicated and the removal of the uterus is required; (2) when the child is dead and the uterus already infected; (3) in extensive atresia of the vagina, preventing discharge of lochia; (4) in carcinoma of cervix; (5) in atony of the uterus or uncontrollable hæmorrhage from the placental site; (6) in cases of ruptured uterus where suture is unsafe.

The original Porro operation has been expanded to include all operations which terminate in the supra-vaginal amputation of the uterus, and even to cases demanding total hysterectomy. The advantages of the Porro method lie chiefly in the prevention of hæmorrhage *post-partum* and the diminished chance of infection.

J. F. J.

#### PERFORATION. PERFECT RECOVERY OF THE CHILD AFTER DELIVERY.

PERNICE (*Centralb. f. Gyn.*, 1900, No. 35) tells of a girl of a year and three quarters with prolapse of the brain through an opening in the skull made during birth by a Nügel's perforator, and subsequently healed with bone. After perforation the head (1st position) was extracted by forceps; hemiplegia ensued but gradually disappeared. At present the child's development, mentally and physically, is quite normal.

#### RUPTURE OF THE UTERUS: ITS TREATMENT.

FORNÉ (*Thèse de Paris*, 1900, No. 503). Expectative treatment, as advocated by Smellie and Denman, and in France by Levret, was condemned in America by Dewees in 1823, and by Trask in 1848; it is not now defended. If the fetus has passed entirely into the peritoneal cavity, laparotomy is generally recommended; and even if it be but partially extruded, this course is advised and practised by Fehling, Bossi and others,

the contraction of the uterine muscle about the child preventing the extraction by the vagina of those parts of the fœtus outside the womb. Even when the fœtus has remained entirely in the womb, the question of laparotomy cannot be at once rejected, except (1) in incomplete, subperitoneal rupture, uncomplicated by hæmorrhage or infection, or (2) in those rare cases in which the appearance of the fœtus at the vulva shows vaginal extraction to be easy and without danger to the mother. The statistics of Trask and Jolly show that laparotomy, even before the days of antiseptics, gave infinitely better results than vaginal extraction, while the mortality under expectative treatment was appalling.

Before laparotomy was so generally adopted, and while extraction by the vagina of the fœtus was the rule, the secondary treatment was naturally by the vagina also—drainage, antiseptic injections, plugging, insertion of sutures, and hysterectomy. Drainage, which marked the first attempt at applying antisepsis (Carl Braun, 1874), was not in vogue except from 1880 to 1885; as early as 1881 it was condemned by Felsenreich, who had been its warm partisan; its inefficacy in controlling hæmorrhage is a sufficient objection to it. The same objection applies to antiseptic injections, save in cases of slight importance. Tamponnement, introduced almost recently by Dührssen, was in 1894 characterised by Dorrman as a sufficient treatment for most cases of rupture of the uterus, though he admitted the occasional necessity of laparotomy; but Schultz (Budapest) was nearer the truth in declaring that “once a sure diagnosis of complete rupture is established laparotomy is a duty. If the rupture be incomplete one should plug with iodoform gauze,” compress the abdomen with a firm flannel binder, and elevate the pelvis. Suture of the uterus *per vaginam*, whatever theoretical advantages it may have over antiseptic injections and plugging as a means for controlling hæmorrhage, has not been often tried. Chomolgoroff did it once successfully in a desperate case; another woman died in spite of it last year. Sutures inserted by the vaginal way *en masse* and out of sight cannot be efficient, like those applied when the abdomen is open, the patient in the Trendelenburg position, and when each bleeding vessel can be seen and separately secured.

In regard to vaginal hysterectomy, incomplete rupture is usually free from serious danger and does not justify such grave intervention in complete ruptures, and direct inspection is of the first importance, which alone indicates laparotomy and excludes vaginal extirpation. If the rupture be complete and the fœtus has been extracted by laparotomy, the subsequent treatment may be stitching the laceration and making a careful toilet of the peritoneum, provided that the uterus is not



myomatous, that there is no focus of infection or uncontrollable hæmorrhage, and that the tear is neither so contused nor tattered nor so gangrenous as to forbid the hope of an immediate union, otherwise hysterectomy, and preferentially total hysterectomy, should be performed.

#### HYSTERECTOMY FOR RUPTURE OF THE UTERUS.

WEISS AND SCHUHL (*Annales de Gyn. d'Obs.*, April, 1900), describe two cases of apparently spontaneous rupture of the uterus during labour which were both treated by abdominal hysterectomy; one patient recovered. The authors recommend abdominal hysterectomy save in slight lacerations, which may be stitched; supravaginal hysterectomy may be done if great haste is indicated. They oppose vaginal hysterectomy, which, proposed by Fehling, has given excellent results in the hands of German operators in uterus rupture. By this route we cannot ascertain the extent to which the laceration may penetrate beyond the limits of the uterus—occasionally even bladder and intestine have to be stitched up.

#### RUPTURE OF THE UTERUS SUB PARTU.

HALBAN (*Centralbl. f. Gyn.*, 1900, No. 25) exhibited at the Vienna Obstetrical Society (January 23, 1900) a 28-year-old II.-para, on whom, twelve days previously, he had performed abdominal hysterectomy some fourteen hours after complete rupture. From the history of the case the rupture must have occurred two hours after the discharge of the waters, and without any great pain or much hæmorrhage. The foetus, slightly macerated, lay free in the abdomen. A laceration of the posterior lip of the cervix, which he refers to the first confinement, had led to a diagnosis of prolapse of the cord. The woman made a perfectly uninterrupted recovery without any fever, and was to be discharged the next day. During an interesting discussion SCHMIT reported that in Schauta's Clinic nineteen cases of rupture had come under observation, ten complete and nine incomplete, with a mortality of nine, *i.e.*, 52·6 per cent. Most of the cases had been examined before admission, and many submitted to various attempts at delivery. Every death was due to sepsis. Not one occurred in consequence of a rupture that had happened in the institution. The percentage of recoveries in those treated by tamponade was fifty-seven, in those by operation fifty. If the anæmia be not so profound as to cause death (and it is not often so, for the bleeding after rupture is not persistent), there is, said Schmit, even theoretically, great probability of tamponade being successful. Delivery in the way that does not expose the abdomen so



freely to further infection should give more favourable results; there is, moreover, free drainage of the wound, and antisepsis is kept up for eight or ten days, or even longer. A review of the published cases confirms this opinion. Of sixty-three treated by drainage in various Clinics 51·8 per cent. recovered; of thirty-three operated upon only 24·2 per cent.

STERN mentioned that in a case of total rupture of twelve hours' standing, as from separation of the recti the child could be felt directly under the skin, Winter (Königsberg) extracted the child and placenta through an abdominal incision which he closed at once, and then performed a vaginal hysterectomy. The whole proceeding took forty minutes, and the woman recovered completely.

R. v. BRAUN said it was well known that Prof. Winter preferred to extract the child by the abdomen—indeed had some years ago proposed after doing so to close the wound and leave the uterus alone. Braun would himself suggest in severe rupture the removal of the uterus, and afterwards the child through the vagina. WERTHEIM objected that the extraction of a large fœtus might cause laceration or tear off ligatures.

LUDWIG pointed out that the advantages offered by vaginal total hysterectomy for the removal of the septic uterus were often more than outweighed by difficulties due to the anatomical complications. It was not always the wound in the uterus to which the serious secondary hæmorrhage and anæmia were due, but also the paracervical vessels, the uterine arteries and their branches. The vessels often retract greatly and cannot with any certainty be seized and secured with forceps from the vagina. Such vessels may cause alarming loss of blood many hours, nay even days, after the patient is supposed to be safe. v. BRAUN explained that the discussion was in connection with an anterior rupture. If the rupture were not transverse and the diagnosis certain he would not be inclined to perform a vaginal total extirpation.

IVANOFF, Kieff (*Centralb. f. Gyn.*, No. 26), records the following case: A. T., laundress, aged 27. Labour began June 23, cross-birth and prolapse of the arm. The pains were strong and she had no skilled assistance. At night, after severe pain in the hypogastrium and hæmorrhage, collapse. Admitted into the hospital, June 24, at 5.30 a.m., very anæmic; pulse weak, 120. Externally: abdomen very tender, small parts easily palpable; bleeding from the vagina. Internally: a laceration of the cervix and lower part of the corpus could be felt on the left side. The placenta lay in the vagina, the fœtus in the abdomen. The uterus was contracted. There were numerous erosions on the portio vaginalis and a purulent discharge, probably gonorrhœa. After two injections of camphor and half a

litre of normal salt solution subcutaneously, and slight chloroform narcosis, the child was extracted by the foot, with some difficulty on account of the small size of the opening in the left vaginal vault. The uterus was then removed in the regular way, and a quantity of blood-clot and some meconium taken from Douglas' pouch; the lower part of the abdomen was plugged with sterile gauze. The male fœtus weighed 3,600 g., was 51 cm. long, 36 cm. round the head, 35 cm. round the chest; placenta 650 g., umbilical cord 58 cm. Vomiting began about noon and lasted all day. On the third day, forty-eight hours after the operation, the forceps were removed and the drainage was changed, and meconium as well as blood was seen. Temperature that evening 38.5°; stool on the fourth day; calomel on the sixth; the drainage was changed daily; suppuration was first noticed on the fifth day. Fever for eleven days, highest temperature, 39.6°. The patient got up on the fourteenth day, and left the hospital quite well on the thirtieth. For his former successful case, v. B. G. J., vol. xv., p. 114; for Merten's *Monats.*, August, 1899.

#### RUPTURE OF THE UTERUS.

WIEDEMANN reported a case to the Medical Society of St. Petersburg (*St. P. med. Woch.*, August 3, 1900), fatal after perforation and four futile attempts at extraction by the cranioclast (successful the fifth time reapplied); placenta in abdomen easily removed. The uterus was torn from the vagina in front and at either side, only adhering by a relatively small portion of the posterior lip. Laparotomy, laceration on anterior surface extending to right art. uterina. Rupture of anterior fornix, with separation of the uterus from the bladder and vaginal insertion for half the periphery. Bladder completely detached, and the peritoneum dragged up to the tubal insertion by sugillations. Total extirpation on the ground of pyrexia, and probable infection from examinations and attempts at delivery before admission.

The results of laparotomy for rupture of the uterus are very unfavourable, yet most authorities, *e.g.*, Fehling, Leopold, Fritsch, Olshausen, Ahlfeld, agree, in case of complete rupture and exit of child and placenta into the abdominal cavity, in performing laparotomy and stitching the wound in the uterus or, if necessary, extirpating the organ.

It is most desirable, when possible, to extract the child *per vias naturales*; the position and extent of the laceration can then be ascertained. The danger of another pregnancy after spontaneous healing must be considered.

BAUR, Berlin (*Centralb. f. Gyn.*, 1900, No. 39), relates a case

of rupture of the uterus during a protracted labour in a 25 year old II.-para with a generally contracted pelvis. The dead child was extracted by forceps; the placenta, free in the abdomen, by traction on the cord. The uterus was plugged with iodoform gauze. The patient, in spite of a feverish childbed complicated by catarrhal pneumonia, was quite well in four weeks. Discussing complete rupture and its principal dangers, hæmorrhage and infection, Bour concludes that one should operate when there is immediate danger from hæmorrhage, but that otherwise one may adopt a conservative treatment provided that delivery by the natural way can be effected safely for the mother.

FRANZ, Halle (72 Cong. N. u. Aertze, October 18, 1900), reported upon twelve cases of rupture of the uterus, ten complete, two incomplete. In his opinion the signs of impending rupture are not always well marked. In only one of four cases under his own observation were there before the rupture any signs of excessive tension. And even after rupture has occurred the symptoms at first may be very slight. Death in these cases is due to hæmorrhage or infection and as it is impossible to be sure that there has in any particular case been no infection every one must be treated as if infected. Total extirpation *per vaginam* is to be preferred when conservative treatment, which should always be considered in the first place, is contraindicated.

FRITSCH remarked that the danger lies less in the laceration of the uterus than in that of the parametrium, it is from the latter that the hæmorrhage comes. Old cicatrices of the parametrium which interfere with the capability of the uterus for distension, are important ætiological factors for rupture of the organ.

v. GUÉRARD, Düsseldorf, attributed a predisposing action to general diseases, especially to nephritis. In five cases during the last year he found two associated with severe nephritis and one with diabetes.

#### INVERSIO UTERI SUB PARTU.

ERDEY (*Orvosi hetilap.*, 1900, No. 23), at the Buda-Pest Medical Society (January, 1900), exhibited a III.-para whose two former labours had been normal; in the last, after the placenta had been retained an hour and a quarter and the uterus under massage and pressure had been inverted and, with the placenta still partially attached, had been forced out of the vagina, the uterus, still inverted, had been returned into the vagina and a tampon of iodoform gauze applied to arrest the hæmorrhage. Erdey, an hour later, tried in vain to reduce the inversion of the uterus, which had already become œdematous. The woman was extremely weak, and bleeding went on

till the colpeurynter had been repeatedly reapplied. Musk and camphor were given hypodermically, 1.5 litres of brandy and water by the rectum, and 400 grammes of normal salt solution subcutaneously. Her general condition improved, and renewed bleeding was controlled by colpeurynter and tamponade, but the hypodermic wounds became infected, the outer side of the thighs became gangrenous. She was admitted into the clinic on the fifth day, and on the eleventh, when the everted surface had become clean, the inversion was reduced under chloroform—the external hand dilating the funnel of the inversion—drainage, tampon, and ergot. The tampon was removed in two days, and the woman was discharged in seven weeks.

THE FREQUENCY AND SIGNIFICANCE OF INFARCTS OF THE PLACENTA, BASED UPON THE MICROSCOPIC EXAMINATION OF FIVE HUNDRED CONSECUTIVE PLACENTÆ. By J. WHITRIDGE WILLIAMS. *Amer. Jour. Obstet.*, June, 1900.

This paper contains a full history of past inquiries into the pathology of the placenta. The following are chief varieties of infarcts noticed:—(1) Small, whitish or yellowish fibrous areas, occurring either on the foetal or maternal surface of the placenta, in size from such as are hardly visible to the naked eye to those having a diameter of several centimetres. These areas are sharply marked off from the surrounding placental tissue, and have rarely a thickness of more than a few millimetres. (2) Triangular or irregularly round areas, usually dull white in colour and presenting a striated, fibrinous appearance. These also are sharply marked off from surrounding tissue. (3) Whole cotyledons converted into a pale white, dense, more or less fibrous mass, in which one fails to observe the usual spongy structure of the placenta. A half, or more, of the entire substance of the placenta may be occupied by such an infarct. (4) A broad rim of whitish material may extend around the margin of the foetal surface of the placenta for a varying distance, at times even completely round the periphery. Such bands may be as little as two or three millimetres or as much as three or four centimetres in breadth. They lie beneath the amnion and are rarely more than a millimetre or two in thickness. Instead of being marginal, the band may lie between the margin and the centre but concentric with the former. (5) Larger or smaller portions of the placenta very variable in size are occasionally occupied by a pinkish mass irregularly shaped, more or less solid, and sharply defined. Usually most marked on the maternal side, they may extend through its entire thickness. They are called infarcts. The author thus summarises the results of his own investigations:—(1) Infarcts measuring at least one centimetre in diameter were observed in 315 out of 500 consecutive



placentæ (63 per cent.). (2) Smaller infarcts, many just visible to the naked eye, were observed in the great majority of placentæ, while microscopic examination revealed early stages of infarct formation in every full-term placenta. (3) In the great majority of cases the main factor in the production of infarcts is to be found in arterial changes in the villous vessels. These are usually manifested as an endarteritis of an obliterative character, with which periarteritis is not infrequently associated. The changes are particularly well marked in the vessels of the medium sized villi, but are less prominent in the large villous stems and the terminal branches of the villi. The degree of obliteration of the lumen of the vessels varies markedly; in some cases there is only a slight bulging of the intima, while in others the lumen is almost obliterated. The arterial changes are identical with those observed in obliterating endarteritis in other parts of the body. (4) As a result of the interference with the arterial supply of the villi, changes are observed in the portions of the stroma which lie just beneath the syncytium. The nuclei of the cells in question become somewhat larger, more irregular in shape, and gradually lose their ability to stain with the ordinary reagents; they undergo coagulation necrosis. The protoplasm of the cells appears less well differentiated, and adjacent cells fuse together, while in the intercellular spaces between them a tissue gradually makes its appearance which is analogous to Langhan's canalised fibrin. In the early stages the syncytium is not affected, and it does not appear to undergo marked changes until a layer of canalised fibrin has been formed beneath it. Why are these first changes first observed beneath the syncytium instead of in the syncytium itself? The answer to this question is that the syncytium, lying in direct contact with the maternal blood, practically serves as an endothelium for the intervillous spaces, and probably plays an important part in preparing it for transmission to the foetal vessels. It is probably nourished by the maternal blood, so that it will not begin to degenerate until the condition of the tissue beneath it renders its further preservation unnecessary. Infarct formation does not occur uniformly over the entire placenta, but is limited to larger or smaller groups of villi, so that the beginning of the process is nearly always sharply localised. Gradually the syncytium undergoes coagulation necrosis and becomes converted into canalised fibrin. This occurs in localised areas. As soon as the syncytium of several adjacent villi has been replaced by fibrin the degenerated areas fuse and form the early stage of an infarct. Larger and larger areas degenerate, and eventually there are a number of villi, a considerable portion of whose surface is covered by canalised fibrin, but which are separated by the maternal blood in the intervillous spaces.

Fibrin ferment is set free from the degenerated cells and coagulates this maternal blood. This coagulated fibrin fuses the neighbouring villi together and forms thus a typical infarct. (5) The part played by the decidua in the production of infarcts has been over-estimated. It is more than probable, in many cases at least, that the tissue designated as decidua is really foetal ectoderm. (6) Moderate degrees of infarct formation possess no pathological significance and exert no influence on the mother or foetus; they are to be regarded as a sign of senility of the placenta analogous to the changes which take place in the villi of the chorion leve at an earlier period. (7) Marked infarct formation is not infrequently observed, and often results in the death or imperfect development of the foetus. It is usually associated with albuminuria on the part of the mother, though at present the relation between them cannot be satisfactorily accounted for. (8) Infarct formation is not particularly marked in acute eclampsia, being usually observed only in those cases which were preceded by definite albuminuric symptoms. (9) There is no evidence in favour of the bacterial origin of infarcts.

J. F. J.

ON THE ORIGIN OF CYSTS IN THE PLACENTA.  
By DE JONG (Steenderen). (*Monats. f. Geb. u. Gyn.*,  
Bd. xi. S. 1072.)

The researches of the author were confined to the examination in regard to cysts of the chorion of five placentæ placed at his disposal by Professor Veit. He concludes: cysts of the placenta may be solitary or multiple, they vary in size from microscopic dimensions to 9 or 10 cm. in diameter; they are to be found on the foetal side of the placenta, and generally in the basal layer of the chorion (Winkler's Schlussplatte). They arise from adhesions of parts of the chorionic villi which, after the disappearance of the syncytium, are agglutinated by fibrin apparently secreted by the Langhan's cells. The inner surface of the cysts is lined with Langhan's cells, which may exhibit proliferation and degeneration. They contain detritus, and the secretion of Langhan's cell elements, or clots of blood fibrin. They are not due to local or general disease, and do not themselves give rise to any clinical disturbance.

The fact that cysts of the placenta are seldom or never of practical importance may account for Virchow discussing only one in his work on "Morbid Tumours;" their apparent rarity is no doubt due to many of them escaping notice, the smaller ones because they lie in the tissue of the chorion, the larger because they are broken during labour and their contents taken for *liquor amnii*. A review of the literature concerning them,

especially of the valuable monograph published by Ehrendorfer in 1893, shows that they may originate in (1) the amnion; (2) in the vitelline duct; or (3) in the chorion; on the fœtal surface of the placenta, or in the membrana intermedia (cysts in connection with hydatid moles are not here considered). Their origin is attributed to: adhesions of folds of the amnion; persistence of the vitelline duct or arrest of its contents; adhesions of the chorionic villi, incomplete myxoma formation, infarcts or hæmorrhages.

These cysts invite further investigation of the true and perhaps important function of Langhan's cellular layer in the earlier period of its development. Though some of their elements are active and secreting, the cysts themselves are of a regressive and not of a proliferating nature.

#### THE USE OF NAPHTALINE IN PUERPERAL ENDOMETRITIS.

KIRSTNER (*Sem. Méd.*, July 4, 1900) has used naphtaline with considerable success at the Maternity of Astrachan in puerperal endometritis. His technique is as follows:—The vulva and vagina are disinfected, the uterine cavity wiped out with sterilised cotton wool, and the cervix painted with carbolic glycerine (1 in 3). A long strip of iodoform gauze is then soaked in ichthyol glycerine (1 in 8), powdered with porphyrised naphtaline, and introduced into the uterus. The plug ought to be very firmly inserted in the upper part of the uterus, but may lie more loosely near the cervix. The end of it hangs from the os externum, and the vagina is afterwards plugged with iodoform gauze. Finally an ice-bag is applied to the abdomen and ergotine administered. The plug is removed at the end of from eight to twelve hours, and, as a rule, all fever has disappeared a few hours later, and the discharge is no longer fœtid. If not the uterus is again plugged with iodoform gauze and naphtaline. Kirstner states that it is but rarely necessary to repeat the plugging, and this treatment only fails when it is undertaken too late, and general infection has already commenced.

H. J.

#### HYSTERECTOMY FOR ACUTE SEPTIC METRITIS AND PERITONITIS.

By EGBERT H. GRANDIN (*Amer. Jour. Obstet.*, April, 1900).

Cases of puerperal infection are divided by the author into two main classes, those due to sapræmia and those which he calls lymphatic. In the vast proportion of cases of sapræmia the infection is the result of the decomposition of particles of decidua, or of placenta retained within the uterus. The affection is local from the start and under proper treatment (evacuation and cleansing of the cavity of the uterus) the symptoms dis-



appear. The tendency of this sapræmic form is not to spread beyond the site of infection.

Lymphatic infection spreads throughout the system rapidly, the symptoms are of low and of insidious grade, and, if unrecognised, the infection has travelled beyond the point of entry, before the observer is aware of it, and tubes and ovaries and peritoneum become irreparably diseased. The causal factor of this infection is the streptococcus. As regards the symptoms, differentiation of the prevailing type of infection can be reached by attention to the following factors: "An empty uterus and low grade phenomena, that is to say, low temperature, and pulse rapid, out of proportion to the thermic rise, should suggest streptococcus infection as in the ascendant; whilst the presence of fœtid discharge and the finding of remnants of necrosed decidua or secundines in the uterus, together with high pulse and temperature, suggest the prevalence of the sapræmic type of infection." A *sine quâ non*, therefore, in diagnosis, is a thorough examination of the interior of the uterus. In the very few cases in which it is impossible to make a diagnosis and yet the clinical picture suggests something of grave import as developing, the author pleads for an exploratory abdominal section, not only to verify the diagnosis, but also to adopt such measures as have occasionally resulted in saving even a forlorn hope. Two cases are given in which the exploratory section and the subsequent surgical measures proved of avail.

CASE I.—Patient confined eighteen days previously. Since delivery fever, chills, abdominal pain and purulent vaginal discharge. Temperature ranged from 100° to 103°, pulse from 120 to 130. The author says: "On examination I found a large, boggy uterus above the pelvic brim, a sensation of bogginess in both broad ligaments, the cervical canal open and a purulent discharge issuing from it. The abdomen was slightly tympanitic, the tongue heavily coated, the facies pinched and anxious, the eyes sunken, the sensorium apathetic. The uterus was explored by the finger under chloroform, and found empty. The decidual lining was softened in places, and therefore I was tempted to curette something which to-day I would not approve of.

During curettage the uterus was perforated and abdominal section was forced upon me, and most unwillingly, because careful exploration led me to doubt the implication of the uterine adnexa or of the peritoneum. "On abdominal section the uterus tubes and ovaries were found to be greatly injected and swollen, the tubes enlarged and filled with pus, the uterine parenchyma softened and pitting on pressure." Total hysterectomy was performed. The cavity was flushed with salt solution and plain sterile gauze was carried into the vagina. Within twenty-four hours of this operation the symptoms of acute sepsis



disappeared. The life of the patient was saved by the—as it happened—fortunate perforation of the uterus by the curette.

CASE II.—In April, 1889, a patient with symptoms very similar to those of Case 1, was seen. They followed on an induced abortion at the sixth week. Even under anæsthesia no specific lesion could be discovered. Abdominal section was performed and the cavity found to be filled with sero pus. "On lifting out the intestines the prettiest pathological picture I have seen outside the dead-house was revealed. Uterus, tubes, ovaries and bladder were covered with greenish pseudo-membrane; the veins in the broad ligament were greatly enlarged and filled with thrombi; the broad ligaments were swollen; the tubes and ovaries were swollen and contained pus; the uterus was softened and could be indented by the fingers." Total hysterectomy was performed and after a stormy time the patient recovered.

J. F. J.

#### AUTO-INFECTION.

AHLFELD, Marburg (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 2), insists that a healthy or apparently healthy woman may suffer and may even die from puerperal infection not conveyed by the examining finger, nor by instruments or dressings, &c. Many reasons may be brought forward for the remarkable differences in the statistics of fever and morbidity. At Marburg the greatest importance is attached to the instruction of practitioners and midwives in training in the methods of disinfection. The mortality there after operations averaged only 4 per cent., while elsewhere, as at Halle, it amounted to 11 per cent. For private practice Ahlfeld concedes the use of gloves for examination and operation, but does not admit their use in the hospital. The vaginal douche of 3 per cent. soap cresol solution is recommended only as a single preliminary application; no further irrigation is employed after examination or operation.

From his experience of the last ten years he recommends the establishment of smaller lying-in institutions, thorough instruction of the midwives and physicians engaged in them in the disinfection of the hands (for the physicians a year's experience in a lying-in hospital to be requisite), and the further limitation of some obstetric operations. In Ahlfeld's opinion his theory of auto-infection has gained acceptance; at the same time he says that the chief item in his programme is not the artificial cleansing of the vagina, but the disinfection of the hands.

Puerperal Infection, *v. supra*, Paris Congress, p. 109.

#### THE MATERNAL MORTALITY IN CHILD-BED.

In his address in Obstetrics at the Ipswich Meeting of the British Medical Association (*British Medical Journal*, August 11,

1900), SMYLY said that in the first half of the present century, the mortality amongst parturient women, especially in hospitals, was probably greater than at any other period. The improvement in the death-rate in childbed occurred suddenly in the seventies.

Mathews Duncan, after careful investigation, agreed with McClintock in estimating the mortality in private practice to be not less than 1 in 120. His own results were 1 in 105, McClintock's 1 in 108, and Churchill's 1 in 159. In the face of such results in the hands of the best men, it is idle to talk of the general mortality at that time having been 19 per 10,000 (*i.e.*, 1 in 526·3).

In comparing the results of modern and ancient practice we are obliged to confine ourselves to hospital statistics; the results of private practice are probably a faithful reflection, perhaps some years later, of the teaching in these institutions.

In the Rotunda Hospital, during the seven years (1870-1876) immediately preceding the introduction of antiseptics, out of 8,092 women delivered in the hospital, 169 died; in the seven years 1899 to 1896 there were only 50 deaths among 9,085 the mortality had decreased from 1 in 45·5 to 1 in 181·7. Similar improvement took place in other hospitals. Adopting the classification of the Registrar-General, in the later period the deaths were—from septic infection 1 in 908·5 compared with 1 in 90·9; from accidents of childbirth as 1 in 378 to 1 in 176; and unconnected with childbirth as 1 in 568 to 1 in 238. The decrease is most marked in the mortality from puerperal fever or septic infection. As long ago as 1791, White of Manchester concluded that absorption of putrid matter was the cause of puerperal fever, and directed his treatment towards the prevention of putrefaction, and the elimination of putrid matter should it have formed. He particularly mentions the good effects of emollient or antiseptic injections into the uterus. More than fifty years later Semmelweis traced the excessive mortality at Vienna to cadaveric poison conveyed by the fingers of the attendants, and afterwards formed the opinion that any organic matter in course of putrefaction, especially the discharges of women with septic diseases, and even air charged with putrefactive matter, might cause such fever. By antiseptic measures he reduced the mortality there which, during an epidemic of twenty months' duration, had averaged 16 per cent to 1·27 per cent. But his teaching was met with ignorance, prejudice and obstinacy, and obstetricians have had to learn from surgeons what he would have taught them twenty years earlier.

When in 1870 antiseptic principles were applied to obstetric practice, they practically banished puerperal fever from our hospitals. At first Listerian methods were closely followed, but

it was soon found that many details might with advantage be abandoned—the spray was superseded by the douche, the use of which reached its climax in permanent irrigation (Schücking). Leopold afterwards showed that better results were to be obtained by thoroughly disinfecting the external parts and avoiding unnecessary examinations than by prophylactic douching. Some distinguished French obstetricians still adhere to the latter method, and with good results, but they insist on the observance of a perfect asepsis—the external parts of the patient, the hands of the operator, instruments and even the water must be absolutely pure. In private practice where, to be done two or three times a day, the douching must be entrusted to a nurse, these conditions can hardly be fulfilled.

Clinical experience and bacteriological experiments alike show that it is not possible to ensure the hands being perfectly aseptic, and we therefore learn (1) to avoid, as far as possible, septic contamination; (2) to spare no pains to render our hands as innocuous as possible, and (3) to restrict local interference within the narrowest bounds.

Next to antisepsis, the substitution of external manipulations for needless vaginal examinations is the most important advance in modern midwifery. The internal examination of parturient women should be altogether avoided or restricted within the narrowest possible limits. External examination is safer and gives more information—easier and more reliable.

When puerperal infection is established, local disinfection by antiseptic douching is generally employed. The general treatment most reliable is that introduced by Runge in 1886, cool bathing, nourishing diet, avoidance of internal antipyretics, and free administration of alcohol.

True statistics of the mortality from infection in childbed are not easily got. In 1861-74 Boehr found it, excluding other causes, to be in Berlin 0·65 per cent. (1 : 154); in Prussia (1859-75), nearly 0·8 per cent. (1 : 125). These must be accepted as minima. Ehlers has investigated the records of the Berlin Statistical Registry, the hospital records also, and those of private practitioners, and finds the official mortality 26·77 too low. He estimates death in childbed, 1877-96, for Berlin, 0·4 (1 : 250); for the Prussian State, 0·5 (1 : 200). The mortality is by no means uniform in different provinces, but generally has decreased; and were the seven years, 1870-76, only considered, would no doubt more nearly approach the results of the Rotunda Hospital, as given by Dr. Smyly.



FATAL PERFORATION OF THE UTERUS IN A PLACE ATROPHIED  
AFTER CHILDBIRTH.By BACON and HERZOG, (*American Journal of Obstetrics*, 1900).

A woman, aged 21, fifteen days after delivery in 1897, had severe hæmorrhage from the genital canal and pain in the back and belly. Six months later the uterus was still enlarged and soft, and the internal os was passable for the exploring finger.

A surgeon curetted the uterus, removed from the left side a quantity of tissue which he thought to be placental, and injected about a pint of corrosive sublimate solution (1 in 5,000). The patient vomited during the operation, and died twelve hours afterwards. The surgeon was accused of having performed a useless operation in an imperfect manner, of not having recognised the rupture of the uterus during the operation, and of not having used due care and foresight. Three days after death the autopsy revealed uterine perforation and peritonitis.

F. E.

## PUERPERAL PSYCHOSES.

MEISSNER (*In. Diss. Greifswald*, 1900) relates the following cases:

(1) Contracted pelvis: induction of labour by irrigation under the membranes caused epileptic attacks, which, treated by morphia and chloral, ceased after two days, and before the onset of labour. The mother suckled the child from the sixth day.

(2) Severe eclampsia: after delivery attacks of acute mania against which narcotics were of no use, so that the woman had to be subjected to mechanical restraint. This condition was succeeded for some days by melancholia and then by complete recovery.

We can admit, says C. ZALACKAS, post-puerperal psychoses, but those following gynæcological operations are very exceptional, and when they exist we usually have to do with women predisposed or already afflicted with insanity. There is no connection between the psychoses and the operative procedure. Psychic troubles can be produced as well after any other operation as after ovarian castration. The operation never of itself produces madness. There exists before the operation a psychic state called phobia, which may persist after the operation. In psychoses at precocious menopause a certain predisposition is at work. The fear of mental perturbation should not deter us from operating when the indications are clearly present.—*Le Progrès Medical*.

PARAPLEGIA, SPASTICA NEONATORUM (LITTLE'S DISEASE), DUE  
TO LABOUR COMPLICATIONS.

G. BURKHARDT (*Zeits. f. Geb. u. Gyn.*, Bd. li., S. 143) says:—Little's disease is generally referred to a labour, either premature



or difficult, or resulting in the birth of the child in a state of asphyxia. Signs of cerebral disease are associated with the two latter conditions only.

Burkhardt has investigated the subsequent history of 73 children born in the Wurzburg Frauenklinik during the last ten years under the above conditions. The labours had been, some very protracted, some terminated by various operative measures. The asphyxia in 42 instances was slight or moderate, in 28 was severe. Of all the children, 28 had died at the time of the inquiry (3 only had shown definite signs of disease), 19 could not be traced, 25 were in excellent health, and in one instance only had Little's disease declared itself. The mother of this last child, a thirty-year-old I.-para, with pronounced kyphoscoliosis of the spinal column, had on account of serious dyspnœa been successfully delivered artificially in the thirty-second week of her pregnancy. The child, now 10 years old, exhibited all the symptoms of Little's disease, but with normal cerebation, and with the help of an apparatus for both legs was able to get about very well. It is evident from this investigation that Little's disease but seldom follows even seriously complicated labour, and that the most strenuous efforts must be made to resuscitate even the most profoundly asphyxiated children, without fear of their being afflicted with spastic paraplegia.

#### THE BATHING OF NEWBORN CHILDREN.

MAURAGE (*Lucina*, Agosta, 1900), from the study of 200 children born in the Bandeloque (Pinard's) Clinic, half of which were bathed every day and the others merely washed after birth, has confirmed the results obtained at the Hallé Clinic. The umbilical stump was in every case treated in the same way by a dressing soaked in bichloride of mercury, but the cord separated sooner, and cicatrisation was more rapid and complete in the children who were bathed every day. F. E.

#### THORACOPAGUS.

PALLESKE, Loitz (*Monats. f. Geb. u. Gyn.*, Bd. xii., S. 5), in the third labour of a woman of 22, extracted a head with the forceps after great difficulty, but could not deliver the trunk. A second head was then found in the pelvic inlet, and Palleske, thinking it a case of twins, perforated the head already born with the hope of extracting the second child past the first and in order to obtain room to apply the forceps to the second head. The second head was easily extracted and the existence of a monster was then apparent. There was no further trouble in the labour.

The two fœtus were united from the navel to the upper end of the sternum, and were both well developed. Of their internal organs the very large liver alone was common to both, and the double but incompletely formed heart. Female genital organs.

## NOTES.

THE Tenth Annual Report of the Wolverhampton and District Hospital for Women gives very gratifying evidence of the excellent gynæcological work that is being done there, with results that will bear comparison with the best records elsewhere. In addition to 782 out-patients (4,163 attendances), 203 patients were treated in the hospital, and 203 operations were performed, among which were 58 ventral and 25 vaginal sections. There was but one death, that of a patient operated upon for an ovarian cyst with a twisted pedicle, who died on the eighth day after the operation apparently from cardiac failure after influenza. There were 5 exploratory laparotomies, 7 ventral and 6 vaginal incisions and drainage; 7 ovariectomies for cystoma, 1 (double) for sarcoma and 1 ovarian cystoma removed by the vagina; 2 abdominal pan-hysterectomies for myoma; 4 vaginal hysterectomies and 3 vaginal radical operations; 9 operations for the removal of one or both appendages and 3 conservative operations. Ectopic gestation was dealt with once by the abdominal and once by the vaginal way; vagino-fixation in combination with resection of the ovaries or plastic local measures was done in 10 instances, and the other operations included nephrorrhaphy, inguinal colotomy, removal of the appendix, and 16 operations for the radical cure of hernia. The mortality on the whole was 0.49 per cent., on the abdominal section only 1.204 per cent.

A young lady brought an action against a tramway company in San Francisco for injury received in a derailing accident. An investigation was ordered, and some months before the trial the lady was submitted to an examination by six medical men, who declared to the court that the examination had established the presence of an ovarian or uterine tumour about the size of a cocoanut. They differed as to its exact situation, but as to its presence they all agreed. The plaintiff's witnesses alleged that the tumour had grown rapidly since the examination ordered by the court, and was now four times its then size. The defendants claimed that the plaintiff's troubles came from the tumour and not from the accident, while the plaintiff and her medical advisers attempted to prove that the tumour was really originated by the accident on the tram line. A subsequent event settled the question; the young lady was delivered of a child at term.—(*Lyon Medical*, 1900.) [F. E.]

## SUMMARY OF GYNÆCOLOGY, INCLUDING OBSTETRICS.

*Opinions as to pathology or treatment expressed in the following abstracts are not necessarily endorsed by the editors or their collaborators. Any Fellows of the Society who may be willing to give the editor-in-chief regular assistance in the preparation of this summary are requested to communicate with him. He will be greatly obliged by having his attention drawn to any important work published at home or abroad; particularly so by receiving condensed abstracts of such work from the authors themselves.*

### ACUTE SENILE ENDOMETRITIS.

By L. H. DUNNING. *Amer. Jour. Obst.*, November, 1900.

This is the second paper on this subject by Dr. Dunning, who has previously reported several cases. The pathological features of the inflammation are (a) a thickened endometrium, the free surface of which is devoid of its epithelial layer; (b) increased vascularity with peculiar arrangement of small blood-vessels; (c) small round-celled infiltration; (d) diminished glandular elements, the epithelium of which is desquamating and the lumen filled with granular *débris*; (e) degeneration of the coats of the arteries of the muscular layer; (f) no excess of connective tissue. The inflammation has a tendency to spread to the Fallopian tubes. There is, owing to its thick mucilaginous character, retention of sanguino-purulent fluid in the uterine cavity. The uterus is enlarged, the walls are thickened and the cavity is dilated. The small blood-vessels of the endometrium run to the surface and there end, *i.e.*, they are ruptured at the surface and hæmorrhage is direct. The inflammation may have begun before the menopause, or it may for the first time appear many years after it. Retroversion is an active cause.

The most prominent symptom is a foetid discharge from the uterus. Pain and soreness are always present. There is vesical tenderness and more or less pain on defæcation. The general health may be markedly impaired. It has to be diagnosed from cancer, in one there is no neoplasm, in the other there is. If there is any doubt, a microscopic examination of the scrapings should be made. If left to itself it may prove fatal from the development of an extending suppuration. The treatment is through curettage followed by the application of a caustic.

J. F. J.

PROLAPSE OF THE URETHRAL MUCOUS MEMBRANE IN THE FEMALE. VOILLEMIN. *Thèse de Paris*, 1900.

It is now admitted that a cellular layer lies between the muscular and mucous coats of the urethra, and according to the writer, it is owing to this fact that the mucous coat can slip over the muscular and cause what is known as "prolapse of the urethral mucous membrane," a condition commonly found in children from 2 to 12 years of age, and in women from 49 to 75. The predisposing causes of this condition are dilatation of the urethra, multiparity, and senile involution; while straining furnishes the exciting cause. The diagnosis is easy. The treatment to be adopted depends on the degree of the prolapse and on whether it is reducible or not. If the prolapse is recent and slight, after reducing it, one ought to try the effects of a compress in order to keep it in place, the patient remaining at rest in bed. As a further aid astringents may be tried, and repeated cauterisations with nitrate of silver.

The length of time this treatment requires and its insufficiency in certain cases, render it advisable to extirpate the prolapse in cases in which it reaches the size of a hazel nut. Ligature of the prolapsed portion as formerly practised has been abandoned. Removal can be accomplished by means of an actual cautery, a thermo-cautery, or a galvano-cautery. Excision with the scalpel or scissors, followed by the suture of the cut edges, gives excellent results.

H. J.

THE SO-CALLED "IRRITABLE BLADDER" IN THE FEMALE.

BIERHOFF (*Amer. Jour. Med. Sciences*, December, 1900), writes: When there is tenesmus and frequent micturition, and, while the absence of pus forbids a diagnosis of cystitis, there is neither sugar nor albumen to point to diabetes or nephritis, we end by saying it is a case of neurosis of the bladder or "irritable bladder." The cystoscope and more careful examination have, however, taught us that a pure bladder neurosis is very rare, and that the so-called irritable bladder is to be traced to some tangible abnormal condition of urethra, bladder or neighbouring organs.

*Symptomatology.*—Symptoms are, frequency of micturition and some pain or tenesmus. Normally a woman urinates four to five times during the day and not at night.

Winter defines abnormal urination as "an irrepressible and painful desire to urinate continuously, aroused by small quantities of urine. Bierhoff adds to this definition that the desire does not entirely disappear after passing water.

The pain and tenesmus vary in different patients, and may be most severe before, during, or after micturition.



The urine is fairly normal; it varies in amount, but is not as is generally thought, highly concentrated.

*Causation.*—In fifty-seven cases Bierhoff found the following causes :—

Hyperæmia, alone or as an accompanying condition, in ... ..	14.
Vesical varices, alone or as an accompanying condition, in... ..	5
Cystitis, alone or as an accompanying condition, in	27
Pericystitis, as an accompanying condition, in ...	27
Pregnancy, with accompanying conditions, in ...	5
Cystocele, alone or with accompanying conditions, in	4
Malpositions of the uterus, as accompanying conditions, in ... ..	10
Carcinoma, extravescical, in ... ..	3
Tuberculosis, vesical, in ... ..	1
Nervous conditions, as accompanying conditions, in	4

He describes the appearance of the interior of the bladder under the various conditions.

*The Prognosis* depends upon the cause.

*The Treatment* consists in discovering the cause and removing it. The marked tendency to recurrence is due to the treatment being symptomatic and to the cause being undetected.

In diet the only important rule is to forbid alcohol.

In massage for stretching adhesions due to perimetritic or parametritic exudations, the bands which are in front and affect the bladder are seldom attended to. For such adhesions Bierhoff employs distension of the bladder with warm boric acid solution.

He concludes that : the term " vesical hyperæsthesia " or " irritable bladder " is, in almost every female case, erroneously applied.

" Vesical hyperæsthesia " rarely occurs as a true neurosis ; it is as a rule merely a symptom.

The diagnosis of the cause of vesical irritability depends upon examination of the bladder and all parts in relation with it, and the treatment must be directed against local changes and also against any associated causal factors.

F. E.

#### VICARIOUS MENSTRUATION FROM THE SKIN OF THE LEFT EYELIDS.

DOLGANOV (Wratch, Sept. 9, 1900) records the case of a young girl, whose periods, abundant and perfectly regular, coincided with a sanguineous discharge from the skin of both left eyelids. In its mode of occurrence this hæmorrhage resembled sweat, and so appeared to come from the vessels of

the sweat glands. The microscope showed the presence of a large number of unaltered red blood corpuscles and a small number of white ones. There was nothing in the condition of the eyes to explain these periodic hæmorrhages.

H. J.

#### VAPORISATION.

H. W. FREUND, exhibiting one of the latest and extremely complicated apparatus for vaporisation at the Medical Society of Lower Alsace (June 23, 1900), insisted on the unreliability of vaporisation when applied for a short time only, and the great danger and uncontrollability of its action when applied for longer periods. Extensive necrosis of the mucosa, necrosis of the entire thickness of the uterine wall and peritonitis, are to be noted as conditions contra-indicating energetic vaporisation, for even a short application of the steam may have undesirable or disastrous effects. At the best vaporisation gives no better results than the methods free from danger previously in use.

#### SURGICAL TREATMENT OF UTERINE DISPLACEMENTS.

CHARLES REED (*Amer. Jour. Obst.*, Nov., 1900). This paper does not discuss the general surgical treatment of uterine displacements, but calls attention to a couple of modifications of technique. In the intraperitoneal shortening of the round ligaments, which the author thinks is the operation of choice, he effects his object by making a letter-of-S fold in the ligaments and suturing the limbs of the fold together. Instead of using hæmostatic or vulsellum forceps, either of which may damage the tissues, he secures the ligament in a forceps with four flat prongs, the whole being an inch across. The prongs approximate with sufficient force to hold, without permanently injuring, the ligament, while the needle for suturing the folds may easily be passed between them. The ligament, brought up into the field of operation on the finger, is seized in its middle third by this instrument, which is then turned half round, thus effecting the desired shortening by a simple twist of the wrist. The inner end of the loop is fixed to the cornu of the uterus. In long-standing flexions there is atrophy of the concave and hypertrophy of the convex wall at the point of flexure. This hypertrophied wall offers a resistance to the maintenance of the normal axis of the organ. To overcome this the author removes from the hypertrophied wall a cuneiform segment. In doing this care must be taken not to open the cavity of the uterus. The sutures must be passed so as to control any bleeding.

J. F. J.

THE PERMANENT RESULTS OF ANTEFIXATION.

MAX COHN, Breslau (*Zeits. f. Geb. u. Gyn.* Bd. xliii., Heft. 3), gives an historical review of the various operations (Alexander-Adams', ventrofixation, vaginofixation) for retroflexion of the uterus, and discusses the results in regard to 338 women operated on for this displacement, in Küstner's Klinik during the years 1893-98. The operations performed on 130 women available for examination as to the result had been: in 39 the Alexander-Adams', in 65 ventrofixation, and in 26 vaginofixation; 15 per cent. of the Alexander-Adams' operations, 6 per cent. of the ventrofixations, and 4 per cent. of the vaginofixations were followed by mischances.

On the whole, 91 per cent. were permanently cured; 31 women had conceived after operation; 6 were still gravid, 4 had aborted. His conclusions are that in selecting cases for operation, a sharp distinction must be drawn between mobile and fixed retroflexion, adhesions must be completely remedied before proceeding to operate.

Vaginofixation should not be attempted on women who may conceive, but is to be recommended as the best operation for patients past childbearing. In others the Alexander-Adams is to be reserved for mobile retroflexion, ventrofixation for such as have been adherent; but operative treatment of mobile retroflexion is to be avoided unless demanded by the long duration of the malady, the proved inutility of pessary treatment, or the patient's aversion to such treatment.

BILATERAL INGUINAL CÆLIOTOMY AND SHORTENING OF THE ROUND LIGAMENTS, &c.

A. GOLDSPOHN (*Amer. Jour. Obst.*, Nov., 1901). The salient points in the technique are the following:—(1) Distinct exposure of the real external abdominal ring and grasp of its contents in a forceps, as the most important and useful key to the finding of the round ligament; (2) abstaining from cutting of tissues after that. The aponeurosis of the external oblique muscle is split open bluntly in the direction of its fibres. The lower edge of this severed aponeurosis is readily drawn down or everted and good access to the inguinal canal obtained. This splitting of the aponeurosis affords a broad surface posteriorly, "against which to anchor the round ligament, along with enough of the internal oblique and transversalis muscles to occlude the canal and make hernia impossible, and the severed edges of the aponeurosis are thereby permitted to fall into exact apposition again, because nothing comes in between them." It is unnecessary to incise the internal abdominal ring, "because an opening from 3 to 5 centimetres is usually obtained easily by

stretching it with fingers or a forceps, beginning with a small opening in the peritoneal envelope of the ligament." This opening, made by dilating the internal ring, "is sufficient for the intrapelvic work intended, because the internal abdominal rings are just in front of the normal location of the ovaries and ampullæ of the tubes; wherefore these structures and the posterior surface of the uterus are as easily reached by this route with one finger through a one inch opening as by two fingers introduced through a two inch incision in the linea alba." The author claims that by this double inguinal cœliotomy the condition of the appendages can be better ascertained and delicate conservative work more perfectly done than by a median incision. The actual shortening of the round ligaments can be done to the fullest extent and approximately in its natural channel, the only method permanent in value and that will stand the test of child-bearing.

The wound is closed in four layers. "In the first the edges of peritoneum and margins of the internal ring are caught in a puckering string suture which closes that opening. In the second layer the internal ring, just closed, is covered over and the canal is closed by liberal masses of muscle tissue from the internal oblique and transversalis, by means of from five to seven continuous catgut stitches taken from the extreme outer angle of the cleft in the aponeurosis successively inward to near the pubic spine." The first two or three of these stitches reinforce the abdominal wall over the closed ring, but by each of the remaining stitches toward the median line, the round ligament is pierced at about its centre and becomes placed, as in a sandwich, between the vascular muscle and the posterior surface of Poupart's ligament. In the third layer the aponeurosis of the external oblique is sutured and lastly the skin. After this operation hernia is practically unknown, and the mortality is and should be *nil*.

J. F. J.

#### SHORTENING OF THE ROUND LIGAMENTS IN RETRO-DEVIATIONS AND PROLAPSE OF THE UTERUS.

EBERLIN (*La Gynécologie*, October, 1900) thus sums up the merits of the d'Alquié-Alexander-Adams' operation:—

(1) Of all the operative methods devised for the cure of movable retro-deviations and prolapse of the uterus, shortening of the round ligaments through the inguinal canal is the most rational. It is the least dangerous, and at the same time gets rid of the pathological condition present certainly and completely.

(2) The operation always succeeds if the technique is properly carried out.

(3) The operation does not give rise to any complication or



difficulty in the case of subsequent pregnancies or confinements. The latter in no way interferes with the operative result.

(4) The most certain manner in which to find the ligaments is to open the inguinal canal.

(5) When care is taken to bring correctly together the different layers of the wound there is no risk of the subsequent formation of a herniæ.

(6) Careful separation of the peritoneal investment of the ligament at the inner opening of the inguinal canal is of the first importance, in order to ensure the success of the operation and to prevent subsequent hernia.

(7) It is desirable that authors give the fullest information regarding the after-results of this operation.

H. J.

#### A NEW METHOD OF HYSTERO-LIGAMENTOPEXY.

DEJARDIN, Liège (*Ann. Soc. Belge Chir.*, Oct., 1900), suggests, in genital prolapsus, this operation, which is a combination of the hysteropexy of Terrier and of the ligamentopexy of Beck.

After the usual antiseptic precautions, baths and purgation, chloroform is administered, the bladder is emptied by the catheter, and, in the Trendelenburg position, the extent to which the uterus can be pressed back into the abdominal cavity is ascertained. An incision of 12 to 15 centimetres is made in the linea alba, the sheath of the recti muscles incised and separated, and the peritoneum opened. The uterus having been raised by means of forceps or a tenaculum, or better, with the fingers, the appendages are examined and dealt with, and each round ligament is isolated by means of a ligature and tied at its peripheral end near the inguinal canal, then divided inside the ligature and dissected from its peritoneal covering as far as the uterine cornu. The two round ligaments are now brought out of the abdomen. They may be bent inwards and sutured on the anterior surface of the uterus so as to bring them together in the median line as practised by Spinelli, but the author does not do so. The sutures are now inserted in the abdominal incision in two layers, one comprising the peritoneum, the inferior half of the sheath and of the rectus muscle; the other the superior half of the sheath and of the rectus muscle of each side from the inferior extremity of the incision as far up as the point where the hysteropexy is to be made. Three or four sutures are inserted through the tissue of the uterus in the manner practised by Terrier; the first at the inferior part of the body of the uterus, the second at the middle, and the third close to the fundus. These sutures embrace only, besides the uterus, the peritoneum, and the deeper halves of the sheaths and recti muscles; they are tied and cut. The deep layer of the incision

above the hysteropexy is then sutured similarly to the part below. The round ligaments now protrude through the abdominal incision just above the body of the uterus already fixed to the abdominal wall, and are directed upwards. They are sutured to the superior layer of the aponeurosis or sheath and the superior half of the rectus muscle on each side by means of five sutures, and the superfluous length of the round ligaments is excised. The superficial layer of the incision is then united by interrupted sutures and the operation is complete.

P. Z. H.

#### ON THE FREQUENCY OF RETROVERSION OF THE UTERUS IN WOMEN WITHOUT GENITAL SYMPTOMS.

SCHROEDER, Koenigsberg (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 3), from the consideration of 411 cases in the Koenigsberg Obstetrical Clinic and Polyklinik, none of which applied for advice on account of hypogastric trouble, concludes: The true normal position of the womb is anteversio-flexio, yet it is only in 75 per cent. of women without genital symptoms that this position persists; in 25 per cent. the uterus is displaced backwards, and of these displacements two-thirds are retroversion and one third retroflexion. It appears, therefore, that backward displacement of the uterus is a condition so common that, uncomplicated by genital symptoms, it has no importance and needs no treatment.

#### SPONTANEOUS EXTRUSION OF A MYOMA.

v. WEISS, Saragevo (*Centrallb. f. Gyn.*, 1900, No. 26), relates that a X.-para, aged 35, after her last confinement, a year and a-half ago, for the first time remarked a tumour prolapsing from her vagina. Up to two months ago the tumour could be returned, but it then became irrepressible and began to putrefy. On her admission, this tumour, which proved to be a putrefying myoma, was removed by hand, and she was well in three weeks. v. Weiss believes it to have originated in the posterior wall of the cervix. The absence of other myomata and the spontaneous birth of the last fully-developed and living child, in spite of the obstacle to delivery, is noteworthy.

#### "COMPRESSION OF THE URETERS BY MYOMATA UTERI."

By J. H. MASON KNOX.

*Amer. Journ. Obst.*, September and October, 1900.

Considering the frequency of myomatous uteri, it is remarkable how few cases of hydro-ureter due to myomata are recorded. This scarcity may be due to the complication being overlooked at the time of operation.

Myomata are likely to obstruct the ureters under two con-

ditions : (1) when the tumour is locked in the bony pelvis and, in growing, exerts more and more pressure against the bony walls, or (2) when the tumours are large enough to distend the abdomen and receive the impact of the abdominal walls, forcing them back on the lower dorsal vertebræ or the pelvic brim.

The degrees of ureteral involvement may be described as:—

(a) Moderate ureteral involvement. In this group the pressure on the ureter is slight, there are no special symptoms indicative of such a condition, the course of the disease or the recovery is not affected by it, and the hydro-ureter is only discovered at the time of operation. This group will include a large number of cases, for, with myomata larger than a foetal head, some hydro-ureter will frequently be found. The importance of knowing this lies in the danger of leaving such myomata alone, for this simple and apparently harmless hydro-ureter may be but the initial step in a serious or fatal complication. Several interesting cases illustrative of this group are reported.

(b) Pronounced ureteral pressure. In this the patients complain of definite symptoms indicating interference with micturition. Four previously reported cases are quoted. In one, micturition was attended with much discomfort and marked tenesmus, but after hot applications over the lower abdomen large quantities of urine were passed. At the operation the right ureter was found to pass, for a distance of seven centimetres, directly through the large tumour mass anterior to the uterus. Another complained of retention of urine, which merely dribbled from her when she reclined. In a third the urinary trouble greatly increased. She was obliged to void every few minutes when on her feet, but could pass but a few drops at a time. These two last cases were both relieved by pushing the myoma out of the pelvis up into the abdomen.

(c) Mechanical destruction of renal substance. The kidney substance may undergo atrophy from pressure. A case is referred to in which a large cystic tumour of the uterus was punctured from the vagina. The patient had had no urinary symptoms, but she died six days after the puncture, and at the *post mortem* the right ureter was found occluded at the pelvic brim and greatly dilated above that point. The right kidney was reduced to a mere fibrous sac.

(d) Ureteral pressure with inflammation. In this degree an inflammatory condition of the urinary apparatus has ensued above the point of ureteral obstruction. As a result of the backward pressure the resistance of the tissues of the hydro-ureter and hydro-nephrosis against infection is lowered, and the result may be nephritis or pyo-ureter, and pyelonephrosis or surgical kidney.

Infection of the ureter or kidney followed in twelve instances.

Of the twenty-five cases collected illustrative of this group, many cases of great interest are reported, and include "chronic nephritis," "advanced Bright's disease," "chronic nephritis with congenital cystic kidneys," "pyo-ureter," "chronic pyelitis" and "pyelonephrosis." They are well worth reading in the original article.

From an analysis of the cases it appears that in general the tumours were of a large size, the smaller ones only causing symptoms by being confined in the bony pelvis. In consistence they were firm and unyielding with one exception, in which the uterus was converted in a large cyst containing nineteen litres of fluid. The ureter as a rule was dilated above the pelvic brim only, showing that it is exposed to pressure from a large tumour at that place. In three cases the ureter was lifted up by an underlying tumour and with the neck of the bladder was pressed upon in a postero-anterior direction. In three cases the ureter was adherent and obstructed along a considerable portion of the growth. In two, the ureters were completely surrounded by the myomatous mass.

Adhesions may increase the pressure on the ureters by binding down the myoma to the pelvic wall or to pelvic structures. Kelly bisected the myomatous uterus preparatory to its removal, because firm adhesions prevented the raising of the tumour out of the pelvis sufficiently to extract it in the usual manner.

The symptoms have rarely been suggestive of ureteral pressure; those complained of have been due to the myomatous uterus itself. Examination of the urine has been an unreliable aid. The diagnosis of ureteral compression is therefore difficult. The size and outlines of the tumour must be determined, and also its mobility. If possible the ureters must be palpated upwards and laterally from the bladder and their probable relationship to the tumour estimated. Their actual condition may be determined by catheterisation through the cystoscope. The sudden rush of fluid through the catheter when it passes the point of compression is indicative of hydro-ureter. By the catheter, too, the urine from each kidney can be examined, and, with a waxed tip, the presence or not of a calculus be determined.

Treatment may be (1) expectant, (2) palliative or (3) radical.

(1) Even when a myomatous uterus is causing the patient no inconvenience a careful watch must be kept for the onset of any urinary symptoms. (2) Palliative treatment: the application of warm cloths, the supporting of the patient, and the promotion of elimination of the urine, is permissible only when the amount of ureteral pressure is slight, or when the condition of the patient is such that she cannot stand more radical measures. (3) Radical treatment: the removal of the mass



that causes the pressure may require myomectomy, hystero-myomectomy, or a panhysterectomy, according to the condition present. Serious sequelæ, such as extreme hydronephrosis, pyelonephrosis, &c., will require their appropriate intervention.

J. F. J.

HYSTEROMYOMECTOMY AND MORCELLATION. By O. THIENHAUS.  
*Amer. Jour. Obstet.*, October, 1900.

After reference to the difference between the teaching of Schauta and that of Lapthorn Smith, the two following questions are asked:—

(1) Have vaginal hystero-myomectomy and morcellation advantages when compared with abdominal operations on the myomatous uterus, and what are they?

(2) In what forms of myoma uteri should vaginal morcellation be employed?

In answer to the first question the author points out that by adopting the vaginal instead of the abdominal route, the severity of the shock is much diminished, that peritoneal sepsis is much less frequent, that the possibility of ileus occurring is done away with, and also that of hernia. That the operation by the vaginal route is the more difficult of the two is granted, but "difficulties ought not to be a barrier against any method which has acknowledged superior advantages for the benefit of the patient." Complete removal of the uterus is preferred to any operation in which a stump is left, whether extra-peritoneal or intra-peritoneal, and the combined vagino-abdominal method of removing the uterus is, in the author's opinion, the best. In carefully selected cases the conservative operation of myomectomy should be done.

To the second question the author replies: Vaginal morcellation is limited to tumours not extending above the umbilicus, and which it is possible to displace in narcosis into the small pelvis. It therefore follows that cases with large adhesions of the myomatous uterus to other abdominal organs are excluded from vaginal morcellation. Nor are myomata which have invaded the broad ligament suitable for morcellation. The capacity and rigidity of tissue of the vagina must always be taken into account.

In cases which are exhausted from menorrhage or continuous metrorrhagia, and which show that wax-like colour which is typical in women suffering from submucous myomata, vaginal hysterectomy and morcellation is the best method, because "these patients, owing to degeneration of the heart muscle and lack of vital energy, are more susceptible to peritoneal septic infection and yield more easily to operative shock."

J. F. J.

## THE TREATMENT OF FIBROIDS IN THE NON-PREGNANT UTERUS.

FISH (*Amer. Jour. Obst.*, November, 1900) draws the following conclusions:—

*Myomectomy* is the operation of choice; (1) when the tumour is pedunculated; (2) when it is single, whether subserous, interstitial, or submucous, and can be enucleated without loss of uterine tissue, and the tumour cavity can be closed and covered with peritoneum; (3) when the desire for an heir outweighs all other considerations.

*Hysterectomy* is indicated (1) when the tumour involves so much of the uterus that a cavity too large to be properly closed, and covered with peritoneum, would follow its removal; (2) when several tumours exist, especially little nodules; (3) when the adnexæ are diseased to such an extent that they must be sacrificed; (4) when the disease ceases to be local; (5) when hæmorrhage, pressure, or great pain is a persistent symptom; (6) whenever malignancy is suspected, or the tumour is of rapid growth; and (7) after the change of life.

*Palliative Treatment* should be adopted (1) when the patient is very much reduced from loss of blood—as a prelude to radical cure; (2) when the co-existence of chronic nephritis, diabetes, tuberculosis or other constitutional disease forbids radical cure; (3) when the tumour is small, the main annoyance hæmorrhage, and the patient is past forty years of age, and herself desirous of awaiting the effect of the menopause.

J. F. J.

## INDICATIONS FOR MYO-HYSTERECTOMY AND HYSTERECTOMY FOR MYOMA OF THE UTERUS.

MACNAUGHTON-JONES (*Edin. Med. Jour.*, December, 1900) discusses the possibility of formulating definite rules of practice in advising hysterectomy or myo-hysterectomy for myomatous tumour or tumours. He excludes the question of myomectomy, assuming it to be the ideal operation for myoma whenever it can be practised, a conclusion to which the majority of Continental and American surgeons have come, accepting the view that early interference by this step must be the line on which future progress is made.

He approaches the subject from two points of view: first, the biological, morphological, and histological grounds connected with the tumour itself and its immediate surroundings; and, secondly, the associated clinical complications, whether present at the time or likely to follow its further growth and development. The propriety of the operation of hysterectomy has to be determined under so many diverse conditions and circumstances that our resolve to operate or not must depend upon the special

features of the individual case in which a decision has to be arrived at.

The possibility of alternative treatment, the character, position, and attachments of the growth or growths; the apportionment of the internal and adherent dangers incidental to the tumour itself in its pathological features and surrounding complications; the mode, direction, and rapidity of growth; the various degenerative changes possible in a myoma, the question of urgency, as apart from expediency arising out of immediate dangers attendant upon the tumour, are relatively and categorically considered. The tumour which may be borne with comparative comfort to-day, may, in a year's time, or even less, involve the bowel, causing obstruction; the bladder, resulting in incontinence; the kidney, by ureteral pressure, or locomotion, by pressure on the sciatic nerve. So rare are the degenerative changes, sarcoma and carcinoma, in a myoma, that there is little justification in considering these as a determining factor of operation. When they do exist as complications of myoma, only in the most exceptional cases are they *secondary* degenerations of the growth itself. Not so the mucoid, colloid, calcareous, and necrobiotic changes. Suppurative degeneration ending in septicæmia may result from any one of these.

The enormous size to which cystic degeneration may lead is shown by the case of Mr. Skene Keith, in which the tumour weighed thirty-six pounds, and that of Dr. Worrall, of Sydney, in which the weight was thirty-eight pounds. In both these instances the degenerative growth took place within a period of ten years.

It would be no exaggeration to estimate the proportion of myomata complicated by some form of degenerative change at from 15 to 20 per cent. Of cystic degeneration alone Harrison Cripps found six in eighty cases of myomata, and the tables of Noble and other authorities fully bear out the view that from degenerative changes and other complications, some 30 per cent. of women would die as the result of their disease without operation. This is perhaps a low estimate.

Mere size of tumour cannot decide the expediency of interference, a small tumour from its position and nature may demand it, when a considerably larger one may cause but little inconvenience. He gives instances of this, quoting the case of a patient who for years has had a huge fibroid, equal to the size of the uterus at full term, travelling about and managing a private estate, being otherwise in excellent health.

The bearing which hæmorrhage has on interference, and the results of salpingo-oöphorectomy, ligature of the uterine arteries, or in some cases curettage have all to be considered in relation to the nature and size of the growth. The failure of these

alternatives, while the tumour and its other ill consequences are left, with the more or less depressing anticipations of another operation, are considerations which have to be seriously weighed in those cases in which the hæmorrhage does not yield to palliative measures. The author remarks that if we remember the correlation between cardiac affections and impaired mentalisation and the effect of myoma uteri in causing cardiac hypertrophy or other lesions, and the undoubted concurrence of affection of the pelvic organs in a proportion of insane women, it is a matter for astonishment rather than otherwise that mental affections are not more commonly present when myoma exists than they are.

Of 220 insane women who were examined gynæcologically by Rohé, 128 had lesions of the pelvic organs. Out of 109 autopsies of insane women, in 5.50 per cent. fibromata were found (see Ernest Hall's paper in the November number of the *BRITISH GYNÆCOLOGICAL JOURNAL*, and the abstract in the Summary of the same number, of the author's paper on this subject). That myomata are occasionally contributory factors in the causation of mania, dementia, and melancholia, there can be no doubt.

The occurrence of interstitial inflammation (fibromitis) attended by pelvic peritonitis, with serious constitutional disturbance, peritonitis and ascites are complications which, according to their severity, or recurrent character, may demand interference. With regard to pregnancy, the author accepts the conclusions of Kelly in his differentiation of cases which may demand operation. "Operating when there are no urgent symptoms, on account of dangers which may arise, has no field here." This axiom is in accord with the views of the great majority of British and Continental gynæcologists. "When a tumour is so situated that its removal offers the best chance of saving both mother and child, while non-interference endangers the lives of both, operation should be attempted." The majority of tumours, however, do not cause dystocia or prevent labour, and in the vast majority of cases the tumour should not be interfered with.

Not the least serious of complications are the omental, intestinal, vesical, and rectal adhesions, which are found in a fairly large proportion of cases, and which are serious, not only from their direct effects on the viscera which they involve, should the tumour not be interfered with, but from the greater difficulties attendant upon operation when they are present, as injury to the bowel, bladder, and ureters, not to speak of hæmorrhage entailed by their separation. Equally grave complications demanding operation are the inflammatory, suppurative, cystic, and degenerative changes, as well as neoplasms, of



the adnexæ, which are frequently present with myomata. Their presence will raise the question of salpingo-oöphorectomy, either without interference with the uterus, or combined with supra-vaginal hysterectomy or panhysterectomy. If both adnexæ be diseased to such an extent as to necessitate their removal, then it will be a question as between myohysterectomy or panhysterectomy. Should those of only one side be so involved, and myomectomy be possible, there is no justification for removal of the uterus.

That gynæcologists no longer attach that importance which was formerly attributed to the menopause or climacteric years in its effects on a myoma, is well known. In the majority of cases the myoma is still liable to the various degenerative changes and the woman to the risks attendant on its complications, not to speak of the progressive deterioration in her health, up to a comparatively late period of her life. Indeed, Ludwig Kleinwächter inclines to think that it is during this time the greatest danger of malignant degeneration of these tumours is to be feared. Thus it is a question if, instead of being more hopeful and expectant, we ought not to more reluctantly assume the responsibility of inaction, and the holding out of delusive hopes to those who are suffering from myoma during these years.

Having discussed the ethical question as to how far a woman may be entitled to insist upon operative relief, being fully aware of the risks attendant upon interference, and the bearing of her social position on this decision, Macnaughton-Jones gives the following classification of the principal dangers to life arising from the presence of a myoma:—

(a) *Degenerative Changes in the Tumour*.—Mucoid, colloid, calcareous, sarcomatous, suppurative, gangrenous, necrobiotic, telangiectatic or adeno-carcinomatous.

(b) *Adnexal Complications*.—Inflammatory and adhesive, suppurative, cystic, solid tumours.

(c) *Bowel Complications*.—Obstruction; adhesions, omental or intestinal; appendicitis.

(d) *Peritoneal Complications*.—Peritonitis, pelvic or general: acute, subacute, or septic; ascites.

(e) *Vesical, Renal, and Ureteral Complications*.—Displacement of the bladder and ureters, adhesions, obstruction of ureter, hydro-ureter, hydronephrosis, pyonephrosis, albuminuria.

(f) *Circulatory Complications*.—Hæmorrhage, anæmia, cardiac complications.

(g) *Those Arising from Pregnancy*.—Abortion, miscarriage, ectopic gestation, rupture of the uterus, malpresentations, dystocia, obstructed labour, postpartum hæmorrhage.

(h) *Mental Effects*.—The disorder of mentalisation may vary in degree from the neurasthenic or hysterical state to phases of melancholia, dementia, or mania.

(i) *General Consequences.*—Under this head we may include such consequences of pressure as difficulty in walking, inflammatory changes in the tumour due to exposure or traumatism, axial rotation of the tumour, inversion of the uterus, interference with health consequent upon pain, weight of tumour, constipation, urinary disturbance, and the depression and apprehension caused by the presence of the tumour.

As obvious contra-indications to the operation must be included serious degenerative changes in the kidney or the other abdominal viscera, or profound anæmia associated with organic cardiac conditions. We should ever act in conformity with the well-defined rule, that the operation is never justifiable when obviously the vital power and resistance of the patient are not equal to the shock of the operation, unavoidable hæmorrhage, and post-operative period of pain, with other attendant sequences.

The author entirely adopts the views of Howard Kelly given in his work, and those of Schauta, embodied in his communication to the Amsterdam Congress, that we should always be able to show that the continued presence of the tumour is in some way a menace to life, or that its presence is incompatible with a comfortable existence, and that operative interference is not warranted unless other treatment be futile.

#### FÆCAL TUMOUR.

POTEN, Hanover (*Centralb. f. Gyn.*, 1900, No. 33), detected in a girl of 19, with hypogastric pains, a large abdominal tumour, the nature and origin of which was doubtful. It was supposed to be either a myoma or dermoid cyst, but after some days he found that pressure caused an indentation in the tumour which remained permanent. This being characteristic of a fæcal tumour led to the correct diagnosis and successful treatment of the case.

#### ABDOMINAL INCISIONS.

CARWARDINE (*Bristol Medico-Chi. Journ.*, September, 1900) believes that sphincter incisions by separation of muscular fibres, and the principle of valve action whenever two musculo-aponeurotic layers are super-imposed, are bound to dominate the surgery of the future. He points out that transverse division of a muscle necessarily leads to a scar (muscular continuity not being re-established) and also involves permanent degeneration on either side of the line of section. He advocates incision in the direction of the fibres of the aponeurosis, and separation of its fibres and of those of the underlying muscle in their respective directions. He has several times exposed the kidney with slight division of musculature, by making a long incision

in the direction of the fibres of the external oblique, and commencing the separation of the internal oblique well forwards, the exposure being abdominal rather than lumbar. To reach the gall bladder and bile ducts he prefers "an oblique incision upwards and inwards in the line of the internal oblique, with separation of its fibres, the incision being continued horizontally above, like an  $\Gamma$  opened out."

Dealing with herniotomy the author draws attention to (a) muscular fibres passing from the outer third of Poupart's ligaments into the conjoined tendon and (b) fibres of the external oblique, which on contraction would straighten the lower arch of the internal ring. Straining or coughing is accompanied by contraction of both these sets of fibres, which conjointly act as a true sphincter. He considers Bassini's operation, in favourable cases, by far the most reliable for the radical cure of inguinal hernia. In operating for appendicitis one has only to make an incision in the line of the aponeurosis of the external oblique, to separate its fibres, and then the combined fibres of the internal oblique and transversalis in a direction upwards and inwards, and one has a perfect sphincter-opening which does not really require any sutures afterwards.

In colostomy, median cœliotomy and gastrostomy, the principles advocated have been adapted with success.

J. M.-J. j.

#### THE *ÆTIOLOGY OF CARCINOMA.*

LEOPOLD, Dresden (*La Gynécologie*, October, 1900), in prosecuting his researches into the *ætiology* of carcinoma, in conjunction with Dr. Rosenthal, has especially endeavoured to make more clear the causal relationship which exists between these growths and certain pathogenic neoplasms. After many attempts, he has obtained pure cultures of blastomycetes from fresh portions of four malignant neoplasms in man. They were procured as follows:—one from a case of cancer of the ovary at the fourth attempt; one from a case of bi-lateral cancer of the ovaries at the sixth attempt; one from a case of cancer of the breast and of the axillary glands at the sixth attempt; one from a case of cancer of the uterus at the third attempt. In many of the cultures one can see the blastomycetes under the form of round, or sometimes oval cells, one to three micro-mms. in diameter, and with a central or peripheral nucleus. Leopold's results are summed up as follows:—(1) Blastomycetes have been found in cancer of the fresh ovary. (2) From the fresh tissue pure cultures of blastomycetes can be obtained. (3) The injection of this pure culture into the testicle of the rat causes the growth of a large number of peritoneal nodules to which the animal succumbs. (4) Blastomycetes taken from these nodules will again give pure cultures.



In conclusion there is no doubt that blastomycetes can be the cause of malignant neoplasms in man, and that inoculated from man to animals they can give rise to a neoplasm in the latter.

H. J.

#### ON THE ÆTIOLOGY OF MALIGNANT TUMOURS.

HEGAR, Freiburg (*Hegar's Beiträge*, Bd. iii., Heft 3), discusses the various theories as to the origin of malignant tumours in relation to their clinical symptoms; he gives a most interesting exposition of the remarkable way in which some tissues, such as fat and muscular fibre, may in course of time disappear, while others, such as hair, may increase; of the multiplication of some cells, while other cells perish; of the remarkable capability of proliferation of epithelial cells and their connection with malignant tumours (abnormal hairiness) and of the connection of these tumours with hermaphroditism and precocity. Tuberculosis and syphilis, to which latter he ascribes special influence upon the origin of sarcoma and carcinoma, as also to other micro-organisms whose metabolic products often give an impulse to proliferation, are also thoroughly discussed (*cf.* Leopold *supra*).

In regard to treatment Hegar directs attention to the diminution of differential energy; diet, the avoidance of infection, in particular of syphilis, as also of local pressure and venous hyperæmia, and finally, in advanced cases, to energetic surgical interference.

#### COMMENCING CARCINOMA OF THE CERVIX IN A CASE OF FIBROUS POLYPUS.

R. FREUND, Freiburg (*Hegar's Beiträge*, Bd. iii., Heft 1), found in a fibromatous uterus, removed by vaginal total extirpation, a pedicled, submucous myoma, round which the uterus had become closely applied so that the tumour lay in a bed, two-thirds of which was formed by the corpus and one-third by the cervix. The upper section of the cervix was dilated, the mucosa of that section exhibiting a commencing cylindrical epithelial cancer limited to that part. As the uterus had been curetted some time previously without diagnosis of cancer, Freund thinks that curetting should always include the cervix as well as the cavity of the uterus.

#### IS VAGINAL HYSTERECTOMY AN OPERATION SUFFICIENTLY RADICAL FOR CANCER?

WINTER, Koenigsberg (*Zeits. f. Geb. u. Gyn.*, Bd. xliii., Heft 3), has, to decide the above question, studied all that has been published on the subject, and the whole of the material of the *Berlin Frauen-klinik* up to 1892. In estimating the curability of carcinoma, the percentage of cases capable of operation must be



taken into account, and he found that, taking five years' freedom from recurrence as the test of the cases coming under treatment up to 1892, about 10 per cent. were capable of being cured by vaginal hysterectomy; in cases since 1892, about 15 to 20 per cent.

Winter furnishes equally irreproachable statistics about abdominal extirpation, which is now more and more superseding the vaginal method on account of the unsatisfactory permanent results of the latter.

#### FORMALDEHYDE.

RANOLETTI, Rome (*Medical News*, April 14, 1900), in inoperable carcinoma of the uterus, especially in corroding ulceration of the cervical portion with fœtid discharge and free hæmorrhage, recommends the application of formaldehyde, the strength of the solution being in proportion to the degree of the lesion. A solution of 20 per cent. is an effective siccative and hæmostatic, the infiltration of the tissues is assisted, the discharge is diminished and loses its fœtid smell, and the pain departs.

#### ON THE ORIGIN OF THE HYDATID MOLE AND THE SO-CALLED DECIDUOMA MALIGNUM.

VAN DER HOEVEN (*Weekblad Nederl. Tydschr. v. Geneeskunde*, Nov. 8, 1900), in an important and well-illustrated paper, arrives at the following conclusions: There are grounds for referring the syncytium to the fœtal ectoderm, and the cells of Langan's to the somato-pleura. In a normal placenta the proliferation of these cells is of a character intermediate between ordinary innocent cell proliferation and that of a malignant kind. In a mole, however, these cells have a malignant character. The mole itself is a malignant growth of two germinal layers, in which the signs of malignancy are somewhat less prominent because the cells have free room for their development.

The tendency of the cell elements to develop in broad tracks through Nitabuch's fibrinous layer is one manifestation of malignity. Even in normal pregnancy syncytium may be found in the decidua, but such extensive penetration of the fibrinous layer is never met with. Before or after delivery these cells perish of themselves, or are destroyed by the maternal tissues and so rendered innocuous.

But in the case of a hydatid mole many more cells grow in the maternal tissues; they have, moreover, a much greater tendency to proliferation, and they grow into the muscular tissue. They have more vitality and so develop into deciduoma. This deciduoma will therefore consist of syncytium, syncytium together with Langan's cells, cells of Langan's alone, or perhaps occasionally, of syncytium, Langan's cells and villous stroma.

If the malignancy of the mole is not marked, or if the mole be removed before the malignant proliferation has involved the maternal tissues, no deciduoma is formed.

It sometimes happens, however, that a deciduoma appears when there has not previously been any mole, not even a partial one. Such a deciduoma owes its origin to a placenta, normal in other respects, but containing some epithelial cells with an abnormal tendency to proliferation.

Finally, in exceptional cases tumours described as deciduoma may be true sarcomata of the mucosa or muscular tissue of the uterus, and quite independent of pregnancy.

#### CHORIONIC EPITHELIOMA OF THE VAGINA.

SCHMITT, Vienna (*Centralb. f. Gyn.*, 1900, No. 47), records a case of a multipara of 36, who had had five children and four abortions. Four months after the last of the abortions, which was an hydatid mole, she was admitted to Schauta's Klinik, with two vaginal tumours which when extirpated proved to be true malignant syncytial growths, chorionic epitheliomata. The uterus was in no way implicated, curetted shavings exhibiting merely the ordinary appearance of endometritis interstitialis. The patient seemed, eight months after the operation, completely cured.

Schmorl and Schlagenhauser have already described not only vaginal metastases of primary chorionic epithelioma of the uterus, but also cases of such growth in the vagina, after normal pregnancy or abortion, in which the uterus was perfectly sound, as in this one. Schmitt does not concur with Schlagenhauser's opinion that such growths may be considered a more benignant form of deciduoma, but considers early diagnosis and extirpation essential for cure. He takes the same view as Pick and attributes their origin to non-malignant villi which wander into the vaginal vessels and when there develop malignancy.

#### UTERINE TUBERCULOSIS.

MICHAELIS, Munich (*Hegar's Beiträge*, Bd. iii., Heft 1), demurs to the view of Klebs and Scanzoni, and holds that any part of the female genitals may be the seat of isolated tuberculosis, but the cervix most rarely so. He has had under observation an instance so limited to the cervix in a nullipara of 33, who for two months suffered from irregular and frequent hæmorrhage. There was no pulmonary disease. The os exhibited a small, granulating, easily-bleeding spot the size of a sixpence, and total extirpation was performed under suspicion of cancroïd. In the cervical mucosa were a large number of papillary outgrowths; at the external orifice microscopical examination showed that the squamous epithelium of the portio had perished,

there were Langhan's giant cells in tuberculous tissue, the glands were very few and some of them seemed to be almost solid from exuberant growth and metaplasia of the tissue. The excrescences seen at the external orifice exhibited the appearance of papillary erosion, with here and there the epithelium and connective tissue replaced by a tissue interspersed with giant cells and tubercles. Towards the internal os the changes disappeared, no tubercle bacilli were found and caseation had not begun. The woman is now, 3.5 years *p. op.*, quite well. Michaelis appends two cases of secondary uterine tuberculosis, in which pulmonary affection and parametric bands already existed. The first is interesting from the fact that the uterus contained a polypus that had undergone tuberculous change. The polypus was removed and the uterus curetted. The scrapings contained much epithelial tubercle but few giant cells, while bacilli were plentiful in the polypus.

In regard to treatment, Michaelis distinguishes between primary and secondary disease, in the former trying conservative methods in the first place, in secondary infection removing the diseased parts when possible.

THE ORIGIN OF OVARIAN CYSTS. By MARY DIXON JONES.  
*Amer. Jour. Obst.*, October, 1900.

After reviewing the literature of the subject the authoress cannot find any clear explanation of the origin of ovarian cysts. She says: "I scarcely thought of the origin of cysts till June, 1899, till, when I was about finishing my microscopical investigations in regard to 'Colloid Degeneration of the Ovary,' the thought was forced upon me. I could see again and again the intense inflammation in the cyst wall, and in every instance when the cyst wall was thus inflamed it was separating, crumbling, and the parts passing into the cyst fluid. There could be no mistake; there were the broken remnants of the cyst wall floating out. The cyst was increasing in size, and the intense inflammation of the adjoining tissues showed that it would grow yet larger. Any tissue of the ovary, any structure, can become inflamed, and in any tissue, or in any structure in which inflammation exists a cyst may be developed. This is the beginning and origin of ovarian cysts, the only condition that can produce a cyst of any nature." As the result of inflammation the tissues are reduced to an embryonal condition, then comes the new growth, the cyst formation. Several diagrams are given of sections of the ovary prepared for microscopical investigation. In each section most of the normal structure is destroyed by cyst formation. Each section under the microscope shows profound disease. "The trouble in each patient commenced in



inflammation, local or general oöphoritis. Each complained of great and constant suffering, and for each it was decided best to remove the diseased structures. All were restored to health. From an examination of the respective patients and the microscopic sections of the ovaries the authoress has drawn the following general conclusions: (1) Cyst formations are the outcome of disease; (2) no ovarian cyst, small or large, exists without a previous oöphoritis; (3) other things being equal, the more intense the inflammation the more rapid is the growth of the cyst; (4) there can be no cyst without a reduction of the tissue to protoplasm; (5) this reduction to protoplasm is what we call inflammation; (6) cysts are always the result of inflammation and are always accompanied by more or less pain, distress, and disturbance of the general health.

The intense inflammation often observed in cyst walls and in neighbouring tissues is the reason why so many of these cysts become malignant. Reduce tissue to an embryonal condition and we may get any new formation, carcinoma or other malignant growths. The inflammatory corpuscles of the inner wall of the cysts gradually break off and fall into the cyst fluid. If the cyst is formed in tissues in colloid degeneration, the colloid material passes into the cyst and appears in the fluid. The cyst fluid will partake of the nature of the tissue in which the cyst is formed. It is impossible to describe the illustrations showing this origin of cysts in the detail necessary to show their bearing on the question.

J. F. J.

#### BILOCULAR CYST OF RESECTED OVARY.

FISCHER, Vienna (*Centralb. f. Gyn.*, 1900, No. 31), to avoid the disadvantages of an artificial premature menopause in removing diseased ovaries, left behind a part of the glands apparently healthy. From this remnant within a very short time was developed a bilocular cyst as large as a man's fist and extremely painful, which had to be removed by laparotomy.

#### TERATOMA OVARII WITH METASTASES.

FALE, Hamburg (*Monats. f. Geb. u. Gyn.*, Bd. xii., Heft 3), relates the following case: laparotomy was performed on a woman of 21, on account of ascites and a presumably malignant ovarian tumour. After the removal of the ascitic fluid, a hard lumpy tumour came in view and the entire peritoneum was found bestrewn with small nodes. One of the nodes was excised before the abdomen was closed, and microscopical examination proved it to be a teratoma containing cysts with cylindrical epithelium, smooth and striated muscular fibres, cartilaginous tissue, ganglion cells, skin elements, &c. No sarcomatous



foundation tissue, such as is often found in tumours of this kind, could be detected.

The patient was repeatedly tapped during the two years and eight months she lived after the laparotomy. At the autopsy, a teratoma arising from the right ovary was found, weighing fifty pounds, histologically the same as the removed metastasis. Arising from the left ovary was a similar tumour on which, however, two small cystic embryomata were discovered, but no metastases were found on the peritoneum. No explanation is offered for this remarkable case. [Embryomata is the name given by Wilms to dermoids of the ovary as products of parthenogenetic processes].

#### OVARIAN TUMOURS COMPLICATING PREGNANCY.

MOND, Hamburg (*Münchener med. Wchns.*, 1900, No. 36), in connection with a personal observation and after extensive investigation of pertinent literature concludes:—

(1) Ovariectomy is the only justifiable treatment once an operable ovarian tumour is diagnosed in a pregnant woman. The increase of the tumour in size favours the growth of firmer adhesions, which will complicate its removal, and immediate laparotomy should therefore follow assured diagnosis.

(2) Existing statistics show that the operation gives the best results as regards the mother, when performed in the second to the fourth month, and is least likely to interrupt the pregnancy when done in the third or fourth.

(3) Dangerous results of the complication, such as torsion of the pedicle, suppuration of the cyst, &c., demand prompt surgical intervention.

(4) Puncture of the cyst and artificial induction of labour are to be regarded as last resources only, not as therapeutical measures; in critical cases puncture or even incision is permissible.

(5) In most cases the tumour has been found to increase in size during gestation.

(6) Ovariectomy is indicated even when the patient is not seen till near term.

(7) If labour has commenced, an attempt should be made to repose the tumour under anæsthesia; should the tumour be a small cystic growth, puncture or incision may perhaps be advisable.

(8) If the tumour be a solid one and the foetus alive, the indication is Cæsarean section, with or without simultaneous removal of the obstacle to delivery.

(9) During childbed it is better to wait for a week or two till the question of puerperal infection is decided, and the involution of the uterus is advanced as far as may be.

(10) The tumour has been found to grow and increase in size even in childbed.

## TUBO-OVARIAN ABSCESS AND HOW BEST TO DEAL WITH IT.

RICKETTS (*Amer. Jour. Obst.*, November, 1900) points out that the enucleation of a tubo-ovarian abscess without injury is not an easy procedure, even after the abdomen has been opened. "Its contents are generally most virulent, and should the field of operation be flooded with them great risk is added to the operation." Vaginal incision causes less shock than abdominal section, and vaginal drainage puts the patient in better shape for a final effort by the abdominal route some months later. In uncomplicated cases in poor subjects for operation, when a large abscess with a thin wall is recognised after the abdomen is opened, it is best to consider the advisability of draining by vaginal section without an attempt at enucleation. Should there be a fistula, large or small, communicating with the intestine, vagina, or urinary bladder, it is always best to drain before attacking the same by the abdominal route. The abdominal route may be used as a secondary procedure if deemed advisable.

J. F. J.

## VAGINAL FIXATION OF THE PERITONEAL EXTREMITIES OF THE FALLOPIAN TUBES AFTER SALPINGO-OÖPHORECTOMY, OR SALPINGECTOMY.

MIRONOV (*Méditsinskoïé Obozrénie*, August, 1900) describes for the treatment of inflammation of the adnexa an operation which also aptly prevents subsequent pregnancies. He opens the anterior vaginal *cul-de sac*, and draws down the enlarged appendages after first breaking down all adhesions. He next extirpates the diseased appendages, leaving the ovary if possible. The resulting pedicle is then sutured to the vaginal opening, in such a manner that the ligature controlling the end of it projects into the vagina. Finally the vaginal wound is closed, save in the centre, where a Mikulicz drain is introduced. In the case of nulliparæ with narrow vaginæ, the author recommends the opening of the anterior abdominal wall in order to free the ovaries and resect the tubes. The abdominal wound is then closed, and the ends of the tubes brought down through an opening in the anterior *cul-de-sac*.

H. J.

## BISECTION OF THE UTERUS PRELIMINARY TO THE ABDOMINAL REMOVAL OF DISEASED ADNEXA.

HOWARD A. KELLY, Baltimore (*Phil. Med. Jour.*, November, 24, 1900), who recently advocated bisection of the myomatous uterus in an abdominal enucleation in complicated cases, now calls attention to the great value of a similar procedure in certain cases of pelvic inflammatory diseases. The steps of the operation are these: If the uterus is buried out of view, the

bladder is first separated from the rectum and the fundus found, and if there are any large abscesses, adherent cysts, or hematomata, they are evacuated by aspiration, or by puncture, and the rest of the abdominal cavity is well packed off from the pelvis. The right and left cornua uteri are then each seized and lifted up by a pair of stout museau forceps, the uterus is incised in the median line, and as it is bisected, its cornua are pulled up and drawn apart. With a third pair of forceps the uterus is grasped on one side of its cut surface, as far down in the angle as possible, including both anterior and posterior walls. The museau forceps of the same size is then released and used for grasping the corresponding point on the opposite cut surface, when the remaining museau forceps is removed. In this way two forceps are in constant use at the lowest point, and are commonly reapplied three or four times. As the uterus is pulled up and the halves become everted, it is bisected further down into the cervix. For a panhysterectomy the bisection is carried all the way down into the vagina, using, if necessary, a grooved director to keep the uterine canal in view. For a supravaginal amputation the museau forceps grasp the uterus well down in the cervical portion, and the cervix is bisected. As soon as it is divided and the uterine and vaginal ends begin to pull apart, the under surface of the uterine end on one side is caught with a pair of forceps and pulled up, and the uterine vessels are clamped or tied. The uterus is pulled still further up, the round ligament is exposed and clamped: then, finally, a clamp is applied between the cornu of the bisected uterus and the tubo-ovarian mass, and one-half of the uterus is removed. The opposite half of the uterus is taken away in the same manner. The pelvis now contains nothing but rectum and bladder, with right and left tubo-ovarian masses plastered to the sides of the pelvis, affording abundant room for investigation, as well as for deliberate and skilful dissection. The wide exposure of the inferior, median, and anterior surfaces of the masses offers the best possible avenue for beginning their detachment and enucleation. The operator will sometimes find, on completing the bisection of the uterus, that he can just as well take out each tube and ovary together with its corresponding half of the uterus, reserving for the more difficult cases, or for the more difficult side, the separate enucleation of the tube and ovary after removal of the uterus.

This operation is not recommended to every or any beginner. The surgeon who undertakes it must be calm, deliberate, and must bear in mind at each step the anatomic relations of the structures. Kelly, who has had in his clinic this year abundant opportunities of demonstrating the practical value of this bisection and enucleation of the uterus as a preliminary to a complete



enucleation, by the abdominal route, of tubes and ovaries for pelvic inflammatory and other diseases, sums up its advantages as follows: (1) Additional space for handling adherent adnexa, afforded by the removal of the uterus; (2) greatly increased facility in dealing with intestinal complications; (3) better access, by new avenues from below and in front, to adherent lateral structures; (4) elevation of structures to or above pelvic brim, or even out into the abdomen, bringing them within easy reach of manipulation and dissection; (5) some advantage in approaching *both* uterine vessels by cutting from cervix out towards the broad ligament, than is secured in approaching *one* of them in the continuous transverse incision. In general the time of the operation is shortened; its steps are conducted with greater precision; surrounding structures are far less liable to be injured. In this way there are fewer troubles and sequelæ, and the mortality is lessened.

W. J. S.

#### ABDOMINAL AND VAGINAL METHODS IN PELVIC SURGERY.

DEAVER (*Amer. Jour. Obst.*, November, 1900) says:—"Simplicity means safety, surety, confidence, neatness and a great saving of time." The abdominal route is the more rational and the best way of operation on the pelvic organs in a large proportion of cases. It is simpler of performance. It is safer, as one can avoid distributing infection where infected areas are present. It reduces the danger of peritonitis by general gauze packing. It renders injuries to the bowel, ureters, &c., less likely. It minimises the danger of hæmorrhage. It enables the surgeon to operate with very few instruments, and to see, if necessary, what he is doing. Radical operations *per vaginam* are to be discountenanced for the following reasons: the limited area of manipulation; the impossibility of inspection without destruction and removal of the uterus; the increased liability to hæmorrhage, both primary and secondary; increased danger of injuring ureters, bowel, bladder, and large blood-vessels; danger of doing incomplete surgery; inability to repair injuries to bowel, &c., and to deal safely with an inflammatory mass that involves the vermiform appendix.

J. F. J.

#### NORMAL SALT SOLUTION AFTER ABDOMINAL SECTION.

SIMPSON (*Amer. Jour. Obst.*, November, 1900) finds the chief advantage of infusion of normal salt solution to be in promoting the more rapid absorption of culture media and bacteria, which are thus got rid of before their increasing quantity can endanger life. This method, moreover, is not, like other forms of drainage, fraught with the dangers of external contamination, but while



applicable to almost every kind of case, there are two important exceptions: (1) When ascites is present at the time of operation it shows that absorption of fluids from the peritoneal cavity is very slow, if indeed it occurs at all. If not absorbed, fluids become foreign substances and hence they are objectionable. (2) When enormous doses of bacterial poisons are suddenly poured into the peritoneal cavity owing to the rupture, by accident or disease, of abscesses, or of the hollow viscera. Peritoneal infusions of normal salt solutions will only hasten the absorption of such poison. What is to be aimed at is to stop the absorption and, if possible, to create a flow of fluid from the tissues into the peritoneal cavity (to produce, in fact, an artificial ascites) and at the same time to provide dependent drainage to carry off both the fluid and the bacterial poisons. Dr. Clark's position, in which all intra-peritoneal fluids gravitate into the globular pelvis where absorption is naturally carried on much slower than in the region of the diaphragm, must be adopted.

The author has proved, by numerous experiments upon animals, that glycerin injected into the peritoneal cavity causes a flow of fluid from the tissues, thus creating an artificial ascites. He also presents a radical method of draining the most dependent part of the pelvis, for it is essential that if an "ascites" be produced the removal of the fluid should be efficient. He says: "Our experiments have not been in sufficient numbers, nor is our interpretation of results of sufficient accuracy, to warrant final conclusions for a working plan. They do suffice, however, to convince me, at least, that the theory upon which they were based contains a germ of truth. Whether or not it can be practically applied remains to be seen."

J. F. J.

#### MEDULLARY NARCOSIS.

This subject has excited a good deal of attention during the past year, chiefly through the communications of Oberst, Bier, and Tuffier, and the discussion at the International Congress in Paris. The fact that anæsthesia could be produced in this way was discovered by an American, Dr. Leonard Corning, and published by him in 1884-5, but excited little interest until now.

Dr. JOHN B. MURPHY (*Chicago Clinic*, September, 1900) says "the advantages of the procedure are: ease of application; thorough analgesia of all the tissues below the diaphragm; the retention of the sense of touch; absence of the reflexes; consciousness of the patient; avoidance of the primary, intermediate, and secondary sequences of the anæsthetic, as cardiac phenomena, pulmonary lesions, and renal disturbances."

TUFFIER, in an extensive experience from November, 1899, to August 10, 1900, had no untoward results of any kind, and

secured complete analgesia in every case. Hysterectomies, salpingectomies, nephrectomies, pylorotomies, cholecystotomies, and other operations of the same kind are performed by him regularly under this method of narcosis.

At the November meeting of the Southern Surgical and Gynæcological Association held in Atlanta, Georgia, Dr. W. L. RODMAN introduced a discussion on this subject in far less glowing terms. "No one," he said, "however optimistic he may be concerning this method of producing analgesia, will think of abandoning ether and chloroform. These trusted agents will continue to enjoy the confidence of the profession, and the Corning-Bier method will be held in reserve for certain cases where seemingly there is a clear contra-indication to chloroform or ether. Medullary narcosis should be given subjects suffering from bronchial, pulmonary and renal diseases; to patients affected with fatty or dilated heart, and cardiac diseases in general. It may also be given to old people, in whom the shock of general anæsthesia is oftentimes great, and in drunkards. The choice of a local anæsthetic is of paramount importance. Cocain is difficult to sterilise, as it cannot be boiled without impairing its anæsthetic properties. Raised to a temperature above 180° F., it is decomposed into ecgonin and becomes comparatively inert. By raising it to a temperature of 180° F., and repeating this twice, thrice, or even six times, as recommended by Tuffier, it should be sterile, and therefore safe."

In addition to the difficulty of procuring absolute asepticity, a *sine qua non* to the employment of this method, many experienced operators have also found considerable difficulty in introducing the needle into the subarachnoid sac. Dr. Murphy's claim, therefore, as to simplicity of application is open to question. A more serious objection to the method is that cocain is a very capricious drug, and when injected into the spinal sac is liable to be followed by very unpleasant consequences, such as severe headache, giddiness, faintness and vomiting, which have lasted for days; besides feelings of suffocation, præcordial anxiety, rigors, fever, and even death. In consequence of this BIER has written (*Münchener Med. Wochenschrift*, September 4, 1900) an earnest warning against the general adoption of the method in its present form, and especially against the large doses employed by some operators. "It is our present duty," he says, "not to inject cocain or allied substances, *e.g.*, eucain, peronin and aconin, in the way described by myself and others, but rather to look for means whereby (1) cocain may be injected into the spinal sac as safely as into other parts. This I think I have discovered, so that the chief dangers at least are removed. (2) The unpleasant

after-consequences, vomiting, headache and fever, may be prevented. With this I am at present employed, and expect that they will at any rate be greatly ameliorated. (3) The influence of the drug may be extended, so that operations may be performed on the entire trunk and upper extremities. This also is accomplished. (4) Some non-poisonous method of inducing spinal anæsthesia may be discovered. This has already been done on lower animals, but has not succeeded with human beings." He has not yet published how all this is done, and pleads for time to perfect his investigations.

At a meeting of the Italian Surgical Society, Dr. FUMMI described a series of experiments upon animals and men with a view to extending the anæsthetic influence to the higher parts of the trunk, and stated that by using a solution of cocain in glycerin, the alkaloid was found to reach the highest part of the cerebro-spinal canal, being detected by the very delicate method of Grefel even in the cerebral ventricles. When the patient was placed immediately after the injection in an inclined position, he soon began to experience a sensation of formication and heat advancing from the abdomen to the thorax, and thence to the neck and arms.

Lumbar anæsthesia has also been employed in obstetric practice by Bumm and Marx. The injection was followed by complete analgesia in about five minutes. The uterine contractions became absolutely painless, and scarcely diminished in force. We feel convinced, however, that any practitioner who studies Dr. Marx' carefully tabulated cases and compares the results, especially as regards after effects, with a similar series of cases in which he has himself employed chloroform, will not feel inclined to abandon the old for the newer method.

The general impression we have formed as to the practical value of this method of inducing anæsthesia, is that, excepting in a very limited class of cases, it has not as yet reached a position in which it can be safely recommended for adoption.

W. J. S.

#### ARTERIAL TENSION DURING PREGNANCY AND THE PUERPERIUM.

QUEIREL (13th Méd. Con., Paris) states that from sixty-eight observations, which he has collected with the assistance of M. Reynaud, he has come to the conclusion that the arterial tension—which normally oscillates between 15 and 16 cms. of mercury during pregnancy—is not sensibly affected until the eighth month. At that time there is a tendency for the tension to fall. There then supervenes an increase of tension during labour, especially during the stage of expulsion. Subsequently to delivery the pressure is again lowered, and finally rises in the days that follow confinement until it returns to the normal.



So far as pathological pregnancies are concerned, there is a lowering of pressure in hydramnios, *la grippe*, pneumonia, and in cases where abortion or hæmorrhage is threatening. In albuminuria and eclampsia there is a rise of pressure.

H. J.

#### THE BEST METHOD OF CLEANSING THE BODIES OF PARTURIENT WOMEN.

STROGANOFF (*Vratch*, June 24, 1900) alluding to the large proportion of labours in some of the large lying-in institutions which are still attended with fever (25 per cent. at Ahlfeld's, 29·8 per cent. at Slavjansky's, and 17·7 per cent. at Massena's), reminds us that it is not long since a temperature from 38·2° to 38·8° C. was considered by some obstetricians as normal and due to physiological causes. From experimental investigation he has found that the (immersion) bath is a very uncertain method of cleansing the body of a woman before labour. The water always shows visible grease, and sometimes portions of fluid and solid excreta. It is a means by which germs may be transferred from pustules, boils, and open wounds, harbouring noxious pyogenic cocci, to other parts of the body, such as the nipple—a most undesirable seat for infection in a parturient—or since in certain cases the water finds its way into the vagina, it may so convey infection into the genital canal itself. Moreover the baths themselves, if cleansed merely in the ordinary way, can hardly fail to retain impurities from previous use. The substitution of ablution with running water for bathing by immersion, at Professor Krasovski's clinic, during the course of 1899 and the first five months of 1900, was followed by a decrease of morbidity on the whole number of labours (759) equal to 7·4 per cent. compared with that during the two previous years (807 births). And Stroganoff believes that the adoption of Turkish or Russian baths or washing places with an uninterrupted flow of water, instead of the immersion bath, the more perfect cleansing of the skin thereby, and the diminished risk of infection of the nipples and vagina, would lessen puerperal morbidity—at any rate in pluriparæ.

F. E.

#### SYMPHYSEOTOMY.

LEPAGE (*Comptes Rendus de la Soc. d'Obst. de Gyn., &c., de Paris*, October, 1900) adds seven additional cases of symphyseotomy to those which he has already published. The first was performed in the case of a 11.-para, with a funnel-shaped pelvis (C. V., 9·7 cms.). The child, extracted with the "lévier préhenseur," weighed 3,170 grms.; during convalescence the mother presented signs of cystitis, but both went out well on the twenty-fifth day.



The second case was a III.-para, with a flat pelvis (10 cms. in the C. V.) Child was delivered by the "lévier préhenseur," and weighed 3,740 grms. (Bi-parietal diameter 9.5 cms.). Both went out well.

The third patient was a IV.-para who had symphyseotomy performed on her for the second time (C. V. was 9 cms.). The child was delivered by the "lévier préhenseur." A vesico-vaginal fistula resulted from the operation. The child was born alive but died during the first year. The mother left the hospital cured.

The fourth patient was a II.-para, with a rachitic pelvis measuring 10.7 cms. in the C. V. The child was delivered by the "lévier préhenseur." The cervix, perinæum, and the ureter were torn, with resulting incontinence of urine. The patient left the hospital well save for the urinary trouble; the child also did well.

The fifth patient was a II.-para, with a contracted pelvis measuring 10.3 cms. in the C. V. The face presented, but was corrected to a vertex, and symphyseotomy performed. The child was delivered by the natural efforts. The mother left the hospital well, but the child suffered severely from ophthalmia.

The sixth case was a I.-para with a funnel-shaped pelvis. She also suffered from hydramnios. The child was delivered by the "lévier préhenseur." The patient died an hour after the operation, apparently from the shock of labour and the operation, plus the effect of chloroform on a diseased heart. The child died three days after birth.

The seventh case was a II.-para (C. V., 10.2 cms.). As the head did not descend, the posterior parietal bone presented, symphyseotomy was performed; the os was dilated with the fingers, and the child was delivered by forceps. The patient got an attack of phlegmasia of the left leg on the fourteenth day, but finally left the hospital well. The child died on the sixth day, apparently of broncho-pneumonia.

These symphyseotomies, taken in conjunction with nineteen others Lepage has already performed, give twenty-six cases, out of which one mother and four children died.

PINARD, in discussing Lepage's paper on symphyseotomy, said that he would advise attention to the following points:—

- (1) To give the patients as little chloroform as possible.
- (2) Not to use the "lévier préhenseur."
- (3) To measure with the greatest care the separation of the pubic bones at the moment of the passage of the head, and not to allow such separation to exceed seven centimetres.
- (4) Not to use a solution of permanganate of potash as an intra-uterine injection in cases of post-partum hæmorrhage.

H. J.

CARR (*Amer. Jour. Obst.*, Oct., 1900) reports four cases, and discusses the dangers and objections to symphyseotomy:—

(1) The anæsthetic and the shock. These are common to all operations and are rather less in symphyseotomy than in its alternatives—Cæsarean section or craniotomy. The danger from shock will be much diminished by not delaying the operation till the patient is *in extremis*.

(2) The danger of previous infection from digital examinations, forceps and other manipulations. This danger is unnecessary though real, and cannot properly be charged against the operation. It is greatly lessened by having the operation generally recognised as one of election in proper cases.

(3) The danger of attempting the operation in unsuitable cases, where the pelvis is too small for a safe symphyseotomy. The author limits the operation to a conjugata vera, in a simple flattened pelvis of  $2\frac{3}{4}$  to  $3\frac{1}{2}$  inches and in justo-minor pelvis of  $3\frac{1}{4}$  to 4 inches. The great difficulty is to measure the pelvis with certainty. Digital examination and the knowledge to be gained by a careful use of forceps will be of great assistance. "With the head held against the brim of the pelvis, the finger may be swept around its circumference and a better idea gained of its relative size in comparison to the pelvis than can be obtained in any other way." If the head can be brought down by the forceps low enough to partly engage, then version had better not be tried. If, after the symphysis has been divided, it is found impossible to deliver without a greater separation than  $2\frac{1}{2}$  or at most  $2\frac{3}{4}$  inches, the operation should be abandoned and Cæsarean section or craniotomy substituted.

(4) The danger of lacerating the bladder or urethra or the sacro-iliac ligaments and particular tissues. This is avoided by not making the separation for more than  $2\frac{1}{2}$  inches.

(5) The danger of hæmorrhage due to rupture of the anterior vesical veins. This may be obviated by separating the tissues carefully all round the symphysis, and for  $\frac{3}{4}$  of an inch to 1 inch on each side of the median line before severing the joint.

(6) The danger of sepsis. The wound need not extend nearer to the vulva than the top of the symphysis or about 2 inches above the urinary meatus. The vulva should be kept covered with a sterile towel or gauze. Strict septic precautions should be taken. The subcutaneous operation of Ayers is strongly opposed. After the operation no bandaging or binding will prevent movement of the two bones. Since this movement causes great and prolonged suffering the author has, with complete success, adopted the plan of wiring the bones together.

J. F. J.

## CONTRIBUTION TO THE STUDY OF PLACENTA PRÆVIA.

FROMMEL (*Beiträge z. Geburtsh u. Gynäkol.*, III., 2) relates a curious case of placenta prævia occurring in a woman aged 36, who was suffering from advanced pulmonary and laryngeal phthisis. The hæmorrhage started at about the commencement of the ninth month. On examination, a shoulder presentation with prolapse of the cord was found; the cervix was effaced, and the os the size of a five franc piece. The placenta, which was inserted on the lower uterine segment, covered the greater part of the os, only leaving one small portion uncovered through which the prolapse had occurred. Version was performed and the foetus was expelled two and a half hours later, the placenta following in twenty minutes. The edge of the placenta which lay nearest to the uterine orifice was torn, otherwise there was nothing abnormal. Four weeks later the patient died as a result of the tuberculous lesions. At the autopsy, the uterus was found still large, and the placental site was plainly marked. It was situated on the anterior wall, on the fundus, and on a portion of the posterior wall. Between the lower edge of the site and the uterine orifice there lay a band of absolutely normal mucous membrane, 2 cms. wide on the left, 2.5 cms. on the right.

In spite of the results of the *post-mortem* examination, the author considers that he had to do with a case of placenta prævia, and admits as the only explanation possible that the placenta was developed at the expense of the chorion adherent to the decidua reflexa.

H. J.

## PUERPERAL TETANUS.

SIEBOURG, Barmen (*Monats. f. Geb. u. Gyn.*, Bd. xii., Heft 3), met with a case of severe hæmorrhage from atony of the uterus in a IV.-para of 40, which, after massage and injections of ergot had failed, was finally arrested by clearing the uterus of clots and washing it out with lysol. On account of profound anæmia he administered injections of camphor normal salt solutions subcutaneously, &c. The patient had no rise of temperature till the sixth day, when stiffness began in the muscles of her neck and jaw, followed by pronounced tetanus, and she died on the following day. He was unable to discover the source of the infection.

## INFECTION OF THE UTERINE CAVITY DURING THE PUERPERIUM.

WORMSER, Bâle (*La Semaine Méd.*, November 7, 1900), discusses the question of the freedom of the uterine cavity from bacteria during the puerperium. In many points his conclusions differ from those of Doederlein. The latter authority examined 27 patients who had an apyretic convalescence, and found that in 24 (89 per cent.) the uterine cavity was sterile. He accord-



ingly concluded that "in normal cases the endometrium is sterile during the puerperium." This statement has been more or less supported by others. Dmitri de Ott found a sterile condition in 100 per cent. of the cases he examined (9 cases); C. Czerniewski 98 per cent. (57); Thomen 57 per cent. (7); von Franqué 80 per cent. (10); Walthard 65 per cent. (20); Krönig 79 per cent. (63); Stahler and Winckler 63 per cent. (62). On the other hand, Burkhardt and Franz have found only 15 per cent. of cases to be sterile. The former out of 38 cases found 24 not aseptic, and the latter was able to obtain cultures from all of 10 cases which he examined. Burkhardt therefore concluded that the axiom of the sterility of the uterine cavity is only valid for the days immediately following delivery. Doederlein, seeing his views thus combated, has made a fresh series of experiments, with the following results: Out of 250 patients examined between the second and the fifteenth day after confinement he found the uterine cavity sterile in 83 per cent. In those cases in which such was not the case, he states that the thermometer had shown a slight elevation of temperature. Wormser then started independent investigation, employing identically the same methods of obtaining cultures as those of Doederlein, but with quite different results. Out of 100 cases examined, the majority on the eleventh or twelfth day, a few two to four days later, he found that in 84 the lochia were not aseptic. Almost all these cases were quite well, and only 24 had had a slight elevation of temperature ( $37.6^{\circ}$  to  $38^{\circ}$  C). He accordingly arrives at the following conclusion: In more than 80 per cent. of women who have had an apyretic puerperium, the uterine cavity contains bacteria on the eleventh or twelfth day after their confinement.

The writer then discusses the questions of the origin and clinical importance of these bacteria. The first question is easily answered. The second involves an important point—the theory of auto-infection. Different authors have attributed different meanings to this term. Ahlfeld in effect applies it to all infections due to pathogenic bacteria reaching the genital organs of women before, during, or after confinement, whether spontaneously, by the aid of the finger, or of an instrument. The better definition of auto-infection is the more restricted one of Menge and Krönig, infection from bacteria which have previously flourished as saprophytes in the genital canal. Accepting this definition, is auto-infection to be taken into account? If so, vaginal disinfection before labour is necessary. The writer reports the following comparative results of confinements at Bâle with and without previous disinfection. In 1897: No disinfection; 933 confinements; 81.9 per cent. afebrile convalescences. In 1898: No disinfection: 1,066 confine-



ments; 84.5 per cent. afebrile convalescences. In 1899: Disinfection; 1,225 confinements; and 86.7 per cent. afebrile convalescences. From these figures there was a greater improvement between 1897 and 1898, than between 1898 and 1899. In both cases the improvement was probably due to the general improvement in antisepsis and the consequent prevention of heterogenetic infection. From this and various other proofs, the writer considers that the bacterial flora of the vagina are, as a general rule, incapable of doing much harm or of producing a serious infection.

Of the various heterogenetic which are by far the most common causes, imperfect asepsis of the hands is the most important. Bacteria are almost invariably found in the lochia during the second week after delivery, but after the first week the mucous membrane of the uterus is almost entirely restored, and consequently such bacteria can no longer gain entrance to the tissues. Over the placental site, where this protective layer fails, the presence of clots in process of disintegration offers an unsuitable site for the growth of germs. The latter accordingly lodge in the thrown off decidua and in it are eliminated from the uterus so long as the escape of fluid continues freely. If there is any retention the bacteria multiply rapidly and cause febrile symptoms. If infection should occur a thorough bacteriological examination of the lochia should be made by the aid of cultures and the microscope.

H. J.

#### PUERPERAL SEPTICÆMIA, BACTERIOLOGY AND SERUM TREATMENT.

HERING (*New York Med. Jour.*, 1900, No. 14) considers the treatment of puerperal septicæmia by the antistreptococcus serum fails because: (1) old serum is used; (2) in a mixed infection antistreptococcic serum, useful only against streptococci, must be useless; (3) there is delay in commencing treatment and insufficient doses are used; or (4) the patient is overstimulated. He believes in removing uterine *débris* with the curette, washing out the uterus with perchloride and draining with a single strip of iodoform gauze. Pus, if within reach, should be evacuated *per vaginam*; morphia is contra-indicated; quinine impairs the oxygenation of the blood and increases phagocytosis and is better omitted; stimulants should be cautiously administered; as a rule too much alcohol and strychnine is given, and in excess they act as depressants. The antistreptococcic serum favours phagocytosis. [The chief reason of the failure of anticcocal serums is that they cannot get at the germs in lymphatic and venous sinuses, for which the only treatment is surgical removal or evacuation.]

F. E.

## NOTES.

THE death is announced of Dr. Heinrich Abegg, of Dantzic ; of Dr. Robert Moericke of Stuttgart, formerly Professor of Midwifery at Santiago, Chile ; also of Dr. R. Beverly Cole, Coroner, San Francisco, for thirty years Professor of Gynæcology in the State University.

DR. WM. D. HAGGARD, jr., of Nashville, has been elected to the chair of Gynæcology and Diseases of Children in the University of Tennessee, formerly occupied by his father.

GENEVA.—Dr. Alcide Jentzer has succeeded to the chair of Midwifery and Gynæcology resigned by Dr. Vaucher.

HALLE.—Dr. Hermann Fehling has been appointed the Professor of Midwifery and Gynæcology in succession to Dr. Freund resigned.

NEW YORK OBSTETRICAL SOCIETY.—At the annual meeting of this society, the following officers were elected for the current year : President, Dr. H. J. Bolt ; Vice-presidents, Dr. Ralph Waldo, Dr. H. N. Vineberg ; Secretaries, Dr. G. L. Brodhead, Dr. G. G. Ward, Dr. E. E. Tull ; Treasurer, Dr. J. Lee Morrill ; Pathologist, Dr. W. S. Stone.

THE CHICAGO GYNÆCOLOGICAL SOCIETY at its twenty-second annual meeting elected the following officers : President, Dr. Reuben Peterson ; Vice-presidents, Dr. L. E. Frankenthal and Dr. Henry Banga ; Secretary, Dr. W. H. Rumpf ; Treasurer, Dr. A. H. Foster ; Editor, Dr. C. S. Bacon ; Pathologist, Dr. Emil Ries.

CONSOLIDATION OF THE MARION-SIMS COLLEGE OF MEDICINE AND THE BEAUMONT HOSPITAL MEDICAL COLLEGE.—The governing faculty will include the following : Y. H. Bond, Professor of Gynæcology and Pelvic Surgery ; L. H. Laidley, Professor of Gynæcology and Pelvic Surgery, and Clinical Gynæcology ; W. B. Corsett, Professor of Obstetrics and Gynæcology ; B. M. Hypes, Professor of Obstetrics ; R. C. Atkinson, Professor of Diseases of Children.

DR. GEORGE M. GOULD, who has relinquished the Editorship of the *Philadelphia Medical Journal*, is undertaking the charge of

a new weekly to be called *American Medicine*; the first number is to appear in March.

A MAGNIFICENT Lying-in-Hospital, built and endowed by Mr. J. Pierpoint Morgan, is now approaching completion in New York. The basement is to be devoted to outdoor work, and of the eight super-imposed stories, the first contains the executive offices, the second the nurses' department, the third the septic department, the fourth, fifth and sixth, wards for patients, the seventh the kitchen and laundry, as well as the laboratory, which latter extends up into the eighth.

DR. JAMES MORE reports a breech case in which the foetal vagina was so swollen and congested as to obscure the diagnosis of the presentation. He attributes the condition to the nurse poking her finger into the orifice under the impression that it was the os uteri. (*Lancet*, February 2, 1901.)

MR. STANLEY BOYD communicated to the Clinical Society (January 25, 1901) a successful oöphorectomy for recurrent mammary cancer, in a woman of 31. Mr. Charles Symonds, under whose care the patient had been, confirmed the account of her improvement. Mr. Boyd thinks that even after the climacteric, though there is less chance of success, the operation is justifiable in cases otherwise hopeless.

DR. EGMONT KIRBY reports to *B. M. J.* (January 5), the delivery of a woman in her seventeenth labour of a child weighing 14 lbs. 15 oz., and 21 inches in length. The mother made a good recovery; the child lived only twenty-four hours.

A CASE of extraordinary fecundity is recorded, Lucina, October, 1900. A workwoman in Rome has lately given birth to her sixty-fourth child. Married at twenty-five, she has had successively, a girl, then six boys at once, then five, then three girls and four sons, and a long series of twins, finishing up with quadruplets.—[F. E.]

DR. J. V. WALLACE of Chesapeake City, reported the birth on February 23, 1900, of Warren O—. The grandmother and great-grandmother were present at the birth, while the great-great-grandmother was in a house in the neighbourhood. From this last-named lady, now only 72 years of age, there have sprung eleven children, of whom eight are living, and fifty grandchildren, of whom eighteen are living. There are twenty-two great-grandchildren living, and there have been two great-great-grandchildren, one being the child Warren O—. The total number of this old lady's descendants number eighty-five, of whom sixty-three are living. The number of plural births

is not given, but the oldest daughter, now 52 years old, had twins four times.—*Maryland Medical Journal*.

A MAN WITH A QUIVERFULL.—A French Canadian living in Rhode Island, was recently presented, by his third wife, with his forty-first child. His first wife bore several pairs of twins, and his second three sets of triplets. Thirty-six of the children are living, and many of them, and eight of the grandchildren also, have families of their own. (*Dublin Med. Jour.*, August, 1900.)

HYSTERICAL CRAVING FOR OPERATION.—Dr. Latzko brought before the Vienna Medical Club last November, a patient upon whom, in the course of the last year a series of the most varied operations had been performed.

Up to 1893 she had been healthy, but in that year was in hospital for seven weeks for scarlatina and nephritis. In 1894 she was treated as an out-patient for gastralgia and hæmoptysis, for which she afterwards was in hospital for some months, and was finally transferred to the surgical side, and there, on July 6, 1897, underwent laparotomy for the first time, for symptoms of stenosis. Discharged cured at the end of September, she went to live at Salzburg, where, in June, 1898, she was attacked with rigors, high fever and pains about the right kidney. She was treated as an out-patient, and gradually growing worse was afterwards taken into hospital and underwent another operation—apparently extirpation of the kidney. After seven weeks in the hospital and two months' subsequent attendance as an out-patient, she again fell ill, this time with empyema of the left antrum which, in November, 1898, was evacuated through the alveolar process at Stork's Klinik in Vienna. Following this she had otitis media, for which Professor Politzer found it necessary to trepan the mastoid process. Discharged cured in January, 1899. She again fell ill in November with hæmatemesis and wasting, and lay for five weeks in various hospital wards, but returned in February, 1900, to Salzburg, where, for the troubles last mentioned, she again underwent laparotomy. In March she was back in a Vienna hospital where she submitted to laparotomy for the third time, for ileus and an ovarian cyst on the left side. At the beginning of November, 1900, she came to Dr. Latzko's out-patient room, stating that for some days she had had renewed severe pain in the neighbourhood of the right (extirpated?) kidney and that she was making hardly any water.

The cystoscope showed that urine was discharged normally from each ureter. By bimanual examination a cyst of the right ovary, the size of an apple, was found with an antelected uterus.



Apart from the scars of the laparotomies and other operations there was nothing otherwise abnormal about her body. The case was therefore diagnosed as one of severe hysteria.

Enquiry proved that the first laparotomy, performed for severe troubles presumably due to a gastric ulcer, had revealed normal conditions. The third, for symptoms resembling those of ileus, disclosed an ovarian tumour, the size of a fist, adherent to the sigmoid flexure, which was extirpated. No real obstacle to alvine evacuation could be found. No reports were received as to the second laparotomy or the extirpation of the kidney. The woman, whose appearance is described as a picture of perfect health, is plainly a subject of pronounced hysteria, who imitates the syndromata of disease for the sake of being operated upon.—(*M. M. W.*, 1900, p. 1,680.)

THIRD PAN-AMERICAN MEDICAL CONGRESS.—The following papers were presented at the Third Pan-American Medical Congress held at Havana, Cuba, February 4, 1901 :—

*Section on Obstetrics.*—President, Dr. Eusebio Hernandez; secretary, Dr. Gustav Zinke, 13, Garfield Place, Cincinnati, Ohio. "The Toxicity of the Urine in Pregnancy and its Relation to Puerperal Convulsions," by Dr. Milton J. Duff, Pittsburg, Pa.; "Face Presentation," by Dr. J. A. Lyons, Chicago, Ill.; "The Management of a Myomatous Pregnant Uterus," by Dr. W. W. Wathen, Louisville, Ky.; "Experimental Investigations on Puerperal Sepsis," by Dr. F. Gaertner, Saginaw, Mich.; "The Simultaneous Occurrence of Extra- and Intra- Uterine Pregnancy and a Tabulated Record of Sixty-two Cases collected from 1708 to 1901," by Dr. E. Gustav Zinke, Cincinnati, O.; "Cholemia and Hæmorrhage," by Dr. D. T. Gilliam, Columbus, Ohio; "Renal Insufficiency in relation to Women," by Dr. J. T. Jelks, Hot Springs, Ark.; "Clinical Consideration relating to Cancer of the Uterus," by Dr. A. F. Currier, New York; "The Medication and Treatment of Uterine Fibroids," by Dr. W. B. Chase, Brooklyn, New York.

*Section on Gynæcology and Abdominal Surgery.*—President, Dr. Gabriel Casusa; secretary, Dr. H. P. Newman, 103, State Street, Chicago, Ill. "Cancer of the Fundus Uteri," by Dr. J. M. Baldy, Philadelphia, Pa.; "Treatment of Prolapse of the Uterus," by Dr. H. T. Byford, Chicago, Ill.; "Ureteral Implantation into the Intestines—a New Method with a Bacteriologic and Histopathologic Study of the Kidney," by Dr. Jacob Frank, Chicago, Ill.; "Intestinal Sutures; all Knots Inside," by Dr. F. G. Connell, Chicago, Ill.; "The Complications and Degenerations of Fibroid Tumours as bearing upon the Treatment of these Growths," by Dr. Chas. P. Noble, Philadelphia, Pa.; "Septic Peritonitis," by Dr. C. J. Anderson, Chicago, Ill.;

"The Angiotribe," by Dr. H. P. Newman, Chicago, Ill.; "Shock in Abdominal Surgery," by Dr. F. B. Turck, Chicago, Ill.; "Some Points in the Technique of Hysterectomy, by both Infra- and Supra- pubic Methods," by Dr. W. H. Wathen, Louisville, Ky.; "Cocaine Anæsthesia by Lumbar Puncture in Gynæcology," by Dr. J. Riddle Goff, New York; "Combined or Multiple Surgical Operations at one Seance in Female Patients," by Dr. R. S. Suttan, Pittsburg, Pa.; "When and How should a Ruptured Ectopic Pregnancy be Operated upon?" by Dr. Paul F. Munde, New York; "The Author's Flap Operation for Atresia of the Vagina, with Demonstration," by Dr. Geo. H. Noble, Atlanta, Ga.; "Pelvic Suppuration," by Dr. Joseph Price, Philadelphia, Pa.; "Water: its Uses Internally in Abdominal Surgery," by Dr. W. H. Humiston, Cleveland, O.; "Surgical Diagnosis of Abdominal Tumours," by Dr. W. H. Earles, Milwaukee, Wis.; "The Operative Treatment of Carcinoma Uteri," by Dr. E. E. Montgomery, Philadelphia, Pa.; "Three Dangerous Operations—Repair of Lacerated Cervix, Rapid Dilatation of Cervix, and Curetment," by Dr. John B. Deaver, Philadelphia, Pa.; "On the Desirability of Combined Operations in Pelvic and Abdominal Surgery," by Dr. W. P. Manton, Detroit, Mich.

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OFFICERS, COUNCIL & FELLOWS  
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1901.





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- G. GRANVILLE BANTOCK, M.D., F.R.C.S.Ed. (London).  
T. M. DOLAN, M.D., F.R.C.S.Ed. (Halifax).  
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FOUNDED 1884.

INCORPORATED 1885.

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 Pres., President.  
 V.P., Vice-President.  
 C., Council.  
 Libr., Librarian.

Treas., Treasurer.  
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 Hon. Loc. Sec., Honorary Local Secretary.  
 F.F., Foundation Fellow.  
 L., Life Fellow.

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*Those marked with a dagger (†) are on the list of Resident Fellows, or are non-Resident Fellows who have intimated their wish to receive Agenda Notices of the Ordinary Meetings.*

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- 1885 EMMETT, THOMAS ADDIS, M.D. (New York).  
 1885 HARVEY, ROBERT, M.D. (Calcutta).  
 1885 HEGAR, A., M.D. (Freiburg i. B.).  
 1885 KOEBERLE, F., M.D. (Strasbourg).  
 1885 LAZAREWITCH, J., M.D. (St. Petersburg).  
 1885 MARTIN, A., M.D. (Berlin).  
 1885 TARNIER, S., M.D. (Paris).  
 1885 THOMAS T. GAILLARD, M.D. (New York).  
 1885 WINCKEL, F., M.D. (Munich).  
 1887 BARNES, ROBERT, M.D. (London).  
 1891 POZZI, S., M.D. (Paris).  
 1893 KUFFERATH, E., M.D. (Brussels).  
 1895 LEOPOLD, GEORGES, M.D. (Dresden).  
 1895 ATTHILL, LOMBE, M.D. (Dublin).  
 1899 KELLY, HOWARD A., M.D. (Baltimore).  
 1899 SCHAUTA, FREDERIC, M.D. (Vienna).  
 1900 SAVAGE, THOMAS, M.D. (Birmingham).  
 1900 DOYEN, EDWARD, M.D. (Paris).

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- 1899 †AARONS, SOL JERVOIS, M.D., C.M.Edin., 14, Stratford Place, w.  
 L. 1888 ADAM, GEORGE ROTHWELL, M.B., C.M., Carlton House, 110tham  
 East Street, Melbourne, Victoria, Australia.  
 F.F. ADAMS, JOSEPH, M.B., C.M.Edin., 93, Bewsey Street, Warrington,  
 Lancashire.  
 1896 AICKIN, WILLIAM, M.D., 6, Murray Terrace, Belfast.  
 1888 AIKEN, GEORGE HENRY, M.D., Fresno, California, U.S.A.



## Elected

- F.F. †ALEXANDER, WILLIAM, M.D., F.R.C.S.Eng., 31, Rodney Street, Liverpool.  
C. 1887-9 & 1900-1. V.-P. 1890-2.
- F.F. ALLAN, JAMES, M.A., M.D., *Medical Superintendent Union Infirmary*, Leeds.
- 1896 \*ALLEN, HENRY MARCUS, F.R.C.P. Edin., M.R.C.S.
- 1898 ALLEN, JAMES, M.D., M.Ch., R.U.I., Pietermaritzburg, Natal.
- 1896 †ALLEN, WILLIAM HAMILTON, M.D. Dub., "Clodiagh," Stanmore, Middlesex.
- 1898 APPELBE, E. A., L.R.C.P. Edin., L.F.P.S.G., 1, Southgate Road, Winchester.
- 1885 †ARMSTRONG, WILLIAM, M.R.C.S. Eng., Thorncliffe, Hartingdon Road, Buxton.  
C. 1897-9. V.P. 1900-1.
- 1898 ATKINS, THOMAS GELSTON, M.A., M.D., R.U.I., *Surgeon Cork County Hospital, and Co. and City of Cork Women's and Children's Hospital*, 20, St. Patrick's Place, Cork.
- 1898 BAGNELL, WILLIAM HARRY, L.R.C.S.I., L.R.C.P. Ed., *Officier de Santé Bordeaux*, 4, Rue de Perpigna, Pau, France.
- 1889 BAGOT, WILLIAM S., M.D. Dub., L.R.C.S.I., *Gynecologist to St. Luke's Hospital, Denver, Colo., Ex-Senior Assistant Physician Rotunda Hospital, Dublin*, 402, Opera House Block, Denver, Colo., U.S.A.
- L. 1888 BAKER, CLARENCE ATTWOOD, M.D., 312, Congress Street, Portland, Maine, U.S.A.
- L. 1885 BAKER, WILLIAM HENRY, M.D., *Professor of Gynecology Harvard University, Surgeon to the Free Hospital for Women, Boston*, 22, Mount Vernon Street, Boston, Mass., U.S.A.
- 1898 †BAKEWELL, ROBERT TURLE, M.B. Lond., 27, Welbeck Street, Cavendish Square, w.
- 1887 BAILLERAY, G. H., M.D., 115, Broadway, Paterson, Jersey, U.S.A.
- L. F.F. †BANTOCK, G. GRANVILLE, M.D., F.R.C.S. Ed., *Consulting Surgeon to the Samaritan Free Hospital*, 12, Granville Place, Portman Square, w.  
V.-P. 1884-6 and 1897-9. Pres. 1887. Treas. 1888-90. C. 1891-3.  
Libr. 1894-6.
- L. F.F. BARBOUR, A. H. FREELAND, M.A., B.Sc., M.D., *Assistant Obstetric Physician Royal Infirmary, Edinburgh*, 4, Charlotte Square, Edinburgh.  
C. 1884-8 and 1901. V.-P. 1893-5.
- F.F. †BARBOUR, JAMES, M.D., 48, Talbot Road, Bayswater, w.
- F.F. †BARNES, ROBERT, M.D., F.R.C.P., *Consulting Obstetric Physician to St. George's Hospital, Consulting Physician to the Royal Maternity Charity, &c. &c.*, Bernersmede, Eastbourne.  
Hon. Pres. 1884-1901.
- F.F. †BARNES, R. S. FANCOURT, M.D., M.R.C.P., F.R.S.E., *Physician to the British Lying-in Hospital, and the Royal Maternity Charity, Woldhurstlea, Crawley, Sussex*.  
Late Editor. Hon. Sec. 1884-6. V.-P. 1887-9 and 1892-4.

## Elected

- F.F. †BARRETT, ALFRED EDWARD, M.R.C.S.Eng., L.S.A.Lond., 123, Holland Park Avenue, w.
- 1899 †BARRETT, JAMES FRANCIS, M.B., B.Ch., R.U.I., Edburga House, The Bank, Highgate.
- L. 1886 BARRINGTON, FOURNESS, M.B., F.R.C.S.Eng., 213, Macquarie Street, Sydney, Australia.
- 1898 †BARTER, WILLIAM, M.D., M.Ch., R.U.I., 47, Greencroft Gardens, West Hampstead, N.W.
- 1899 †BARTON, CHARLES NATHANIEL, M.R.C.S., L.R.C.P., 17, Redcliffe Gardens, s.w.
- 1898 BARTON, PERCY FREDERICK, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., 1, Sunny Side, Wimbledon, s.w.
- L. 1885 BATCHELOR, FERDINAND CAMPION, M.D.Dur., M.R.C.S.Eng., L.S.A., L.R.C.P.Ed., *Lecturer on Midwifery and Gynaecology University of Otago*, George Street, Dunedin, New Zealand.  
V.-P. 1893-5.
- L. F.F. †BAYFIELD, HORACE OSBORNE, L.R.C.P.Ed., L.F.P.S.Glas., Tracadie, Merton Road, Wimbledon, s.w.
- 1898 BAYLOR, EDWARD ARTHUR CRAMPTON, M.D.Dub., B.Ch., Ash, Dover, Kent.
- 1892 BECKWITH, FRANK E., M.D., 139, Church Street, New Haven, Conn., U.S.A.
- F.F. BELL, ROBERT, M.D., F.F.P.S.Glas., *Physician to the Glasgow Institute for Diseases of Women and Children*, 29, Lynedock Street, Glasgow.  
C. 1885-7. V.-P. 1891-3.
- 1898 †BELLIS, EDWARD, L.R.C.P. & S.Irel., 81, Holland Park Avenue, Notting Hill, w.
- F.F. †BENNETT, CHARLES HENRY, M.D., M.R.C.S., L.S.A., College House, Hammersmith, w.  
C. 1892-4. V.-P. 1895-7.
- F.F. †BERTOLACCI, JOHN HEWETSON, L.S.A., Beaufort House, Knaphill, Surrey.
- 1886 †BIGGS, MOSES G., M.R.C.S., 101, Northcote Road, New Wandsworth, s.w.
- 1891 BINNIE, M. R. G., M.D., Ryde House, Woking, Surrey.
- F.F. †BIRD, GEORGE GWYNNE, M.R.C.S.Eng., Ellesmere, 451, Edgware Road, w.
- 1898 †BISHOP, EDWARD STANMORE, F.R.C.S.Eng., L.R.C.P.Edin., *Surgeon to the Ancoats Hospital*, 316, Oxford Road, Manchester. C. 1901.
- 1899 BLAIR, JOHN, M.D., Bidston House, Wigan.
- L. F.F. †BLAKE, EDWARD, M.D., Berkeley Mansions, 64, Seymour Street, Hyde Park, w.
- 1898 †BLAKISTON, AUBREY, L.R.C.P. & S.Ed., 5, Grosvenor Street, Grosvenor Square, w.
- L. 1890 BOLDT, H. J., M.D., 54, West 51st Street, New York, U.S.A.
- 1891 †BOURKE, W. H., M.D., 8, Moreton Gardens, s.w. C. 1900-1.
- 1887 †BOURNS, N. WHITELAW, M.D.Brux., M.R.C.S.Eng., L.R.C.P.Ed., 78, Redcliffe Gardens, South Kensington, s.w. C. 1899.

## Elected

- 1887 †BOWIE, ALEX., M.D., C.M., 40, Hertford Street, Mayfair, w.
- 1894 BOYD, ALEXANDER BROOKE, M.A., M.B., B.Ch.Oxon., Richmond, Nelson, N.Z.
- 1887 BOYD, J. ST. CLAIR, M.D., R.U.I., M.Ch., B.A.O., 27, Victoria Place, Belfast.
- L. 1885 BOYD, JAMES P., M.D., *Professor of Obstetrics and Gynecology Albany Medical College*, 152, Washington Avenue, Albany, New York, U.S.A.
- 1891 BREWIS, N. T., M.B., C.M.Edin., F.R.C.P.Ed., 23, Rutland Street, Edinburgh.
- 1893 †BRIDGER, ADOLPHUS E., M.D., F.R.C.P.E., *Physician St. Pancras and Northern Dispensary*, 18, Portland Place, w.
- 1899 BROWN, JOHN HENRY, M.D.Edin., M.R.C.S., 14, Burngreave Road, Sheffield.
- 1896 \*BROWNE, RALPH HENRY, M.D., M.R.C.S., L.R.C.P.Lond.
- L. 1889 BROWNLEE, MILNE, M.D., Woodstock, Ontario, Canada.
- L. 1885 BUDIN, PIERRE, M.D., *Professeur agrégé à la Faculté de Médecine de Paris, Accoucheur de la Charité*, 4, Avenue Hoche, Paris.
- 1887 †BURFORD, GEORGE HENRY, M.B., C.M.Aber., 35, Queen Anne Street, w.
- 1898 †BURKE, PATRICK JOSEPH, M.D., M.Ch., M.A.O., R.U.I., 23, Long Lane, Borough, s.e.
- 1887 BURY, EDWARD CHARLES, M.D. St. And., M.R.C.S., L.S.A., 5, York Row, Wisbech, Cambs.
- L. F.F. †BUXTON, DUDLEY WILMOT, M.D., B.S., M.R.C.P.Lond., *Anæsthetist to University College Hospital*, 82, Mortimer Street, Cavendish Square, w. C. 1895-7.
- 1885 †BYERS, JOHN WILLIAM, M.A., M.D., M.Ch. (Q.U.I.), M.R.C.S.E., L.M.K. and Q.C.P.I., *Professor of Midwifery and Diseases of Women and Children, Queen's College, Belfast, and Physician for Diseases of Women to the Royal Hospital, Belfast*, Lower Crescent, Belfast. Hon. Loc. Sec. C. 1893-5. V.-P. 1896-8.
- 1894 BYFORD, HENRY T., M.D., 100, State Street, Chicago, Ill., U.S.A.
- 1895 CAFFERATA, ADOLPHUS M., M.D., Avenue du Marteau, Spa, Belgium.
- 1887 CALDWELL, W. SPENCER, M.D., Freeport, Ill., U.S.A.
- F.F. †CAMBRIDGE, THOMAS ARTHUR, M.R.C.S.Eng., L.S.A., Stanley Lodge, Waltersville Road, Upper Hornsey Rise, n. C. 1887-9. V.-P. 1890-2.
- 1887 CAMERON, J. C., M.D., *Professor of Midwifery McGill University*, 941, Dorchester Street, Montreal.
- 1895 CAMERON, MURDOCH, M.D., *Regius Professor of Midwifery and Diseases of Women in the University of Glasgow*, 7, Newton Terrace, Glasgow. Hon. Loc. Sec. C. 1899-1901.
- 1898 \*CAMERON, WILLIAM JOHN, M.B.Lond

## Elected

- 1897 CAMPBELL, COLIN GRAHAM, M.B., C.M.Edin., Armagh Street, Christchurch, New Zealand.
- 1894 CAMPBELL, JOHN, M.A., M.D., M.Ch., M.A.O., R.U.I., F.R.C.S. Eng., *Senior Physician Samaritan Hospital for Women, Belfast*, 21, Great Victoria Street, Belfast. C. 1899-1901.
- F.F. CAMPBELL, WILLIAM FREDERICK, L.R.C.P.Ed., L.F.P.S.G., L.S.A.Lond., 43, High Street, Rotherham, Yorkshire.
- 1892 CANNADAY, C. G., M.D., Roanake, Virginia, U.S.A.
- L. 1886 CARSTENS, J. HENRY, M.D., Detroit, Michigan, U.S.A.
- 1891 †CARTER, ARTHUR JOSEPH, M.R.C.S., 75, Shepherd's Bush Road, w.
- F.F. †CARTER, GEORGE ROE, M.R.C.P.I., L.R.C.S.I., Oakhurst, 2, Anerley Park, s.e. C. 1899-1901.
- 1901 CARTON, PAUL, M.D., B.Ch., B.A.O.Dub., *Assistant Master, Rotunda Hospital, Dublin*, 35, Rutland Square, Dublin.
- F.F. †CARVELL, JOHN MACLEAN, M.R.C.S., L.S.A., 24, Queen's Gardens, Brownhill Road, Hither Green, s.e.
- 1898 CARWARDINE, THOMAS, M.S.Lond., F.R.C.S.Eng., 16, Victoria Square, Clifton, Bristol.
- F.F. †CASE, WILLIAM, M.R.C.S., L.S.A., Denmark House, Caistor-on-Sea, Norfolk.
- 1889 †CATTELL, G. TREW, M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng., 30, Hereford Square, South Kensington, s.w.
- 1895 †CHAMBERS, EBER, M.D.Aber., M.R.C.S., *District Medical Officer, City of London Lying-in Hospital*, 1, Wilmington Square, w.c.
- L. 1885 CHAMBERS, P. FLEWELLEN, M.D., 26, West Forty-seventh Street, New York, U.S.A.
- 1898 †CHEETHAM, SYDNEY WILLIAMS, M.R.C.S., L.R.C.P.Lond., 8, Norwich Road, Forest Gate, E.
- 1892 CHENEY, BENJAMIN AUSTIN, M.D., 40, Elm Street, New Haven, Connecticut, U.S.A.
- 1898 CHESTNUT, HENRY, L.R.C.P. and S.Ed., Tralee, Co. Kerry, Ireland.
- 1898 CHESTNUTT, JOHN, B.A., R.U.I., L.R.C.S., L.R.C.P., Derwent House, Howden, East Yorkshire.
- F.F. CLARK, JAMES FENN, M.R.C.S., L.S.A., Clent House, Beauchamp Square, Leamington.
- 1895 †CLARK, TOM, L.R.C.P. and S.Edin., 1, Westbourne Street, Eaton Square, s.w.
- 1898 †CLARKE, JOSEPH JOHN, L.R.C.P.I., L.S.A., 77, Markhouse Road, Walthamstow, N.E.
- 1898 CLARKE, RICHARD ASHMORE, L.R.C.S. & P.I., *Surgeon to Teddington Cottage Hospital*, Goudhurst, Teddington.
- L. 1887 †CLARKE, THOMAS KILNER, F.R.C.S.Eng., M.D., M.A.Cantab., *Surgeon Huddersfield Infirmary*, 66, John William Street, Huddersfield. C. 1895-7.
- 1896 †CLAYTON, CHARLES HOLLINGSWORTH, M.R.C.S., L.R.C.P., 10, College Terrace, Belsize Park, N.W.



Elected

- 1886 CLEGHORN, GEORGE, M.D.Dur., Blenheim, Marlborough, New Zealand. C. 1893-5.
- L. F.F. CLENDINNEN, FREDERICK JOHN, L.R.C.P.Lond., L.R.C.P. & S. Edin., 465, Malvern Road, Hawksburn, Melbourne, Australia. Hon. Loc. Sec.
- F.F. †COFFIN, R. MAITLAND, F.R.C.P.Edin., 3, Westgate Terrace, Redcliffe Square, s.w.
- 1898 †COKER, OWEN COLE, L.R.C.P., L.S.A., 155, Uxbridge Road, w.
- 1899 COLE, J. M. COATES, M.R.C.S., L.R.C.P., Curaçao, Dutch West Indies.
- L. F.F. COLE, RICHARD BEVERLEY, M.D., A.M., M.R.C.S.Eng., Ph.D., San Francisco, California, U.S.A.
- F.F. †COLEMAN, CHARLES ALFRED, M.D.Edin., Hill View, Streatham Common, s.w.
- 1893 †COLENZO, ROBERT J., M.A., M.B.Oxon, M.R.C.S., 91, Cromwell Road, s.w.
- 1890 †COLLINS, E. TENISON, M.R.C.S., L.S.A., 12, Windsor Place, Cardiff. Hon. Loc. Sec. C. 1896-8.
- 1885 CONDON, JAMES HUNT, M.D.St. And., M.R.C.S., L.S.A., L.M.Dublin, *Brigade Surgeon Indian Army Medical Department*, Cawnpore, India.
- L. F.F. Cordes, AUGUSTE E., M.D.Paris, M.R.C.P.Lond., *Privat-Dozent of Midwifery, ex-chirurgien adjoint à la Maternité*, 12, Rue Bellot, Geneva. V.-P. 1897-9.
- 1900 CORRIGAN, WILLIAM JENKINSON, F.R.C.S.I., L.R.C.P.I., L.M., Cloughmore, Splott Avenue, Cardiff.
- 1900 COWEN, RICHARD JOHN, L.R.C.P.I., L.M., L.R.C.S.I., L.M., 25, Clarges Street, Piccadilly, W.
- 1898 CRABBE, JOHN SANDISON, L.R.C.P. & S.Ed., Dundallen, Gravelly Hill, near Birmingham.
- 1895 CRAIG, WILLIAM BEDFORD, M.D., *Visiting Gynæcologist to St. Luke's and St. Joseph's Hospital, Denver, and Professor of Gynæcology in the University of Denver Medical Department*, 122, East Sixteenth Avenue, Denver, Colorado, U.S.A.
- 1900 CRAMPTON, THOMAS HOBBS, L.R.C.P.I., L.R.C.S.I., L.M., 30, Myddleton Square, E.C.
- F.F. CRANNY, JOHN JOSEPH, M.D.Dub., A.B., F.R.C.S.I., *Surgeon to the Jervis Street Hospital, late Examiner in Midwifery, Royal College of Surgeons, Ireland*, 17, Merrion Square, Dublin.
- 1886 CRESSWELL, PEARSON ROBERT, F.R.C.S.Ed., C.B., *Surgeon Merthyr General Hospital, &c.*, Dowlais, Merthyr Tydvil.
- 1888 \*CRICHTON, GEORGE, A.M. St. And., M.D.Edin., L.R.C.S.Edin.
- 1888 †CRISP, ERNEST HENRY, B.A.Camb., L.R.C.P., M.R.C.S., The Lawns, Balham Hill, Clapham Common, s.w.
- 1891 \*CROMIE, JOHN, L.R.C.P. & S.Edin.
- 1891 CROOM, JOHN HALLIDAY, M.D., F.R.C.P.E., F.R.C.S.E., F.R.S.E., *Physician to and Clinical Lecturer on Diseases of Women Royal Infirmary, and Physician to the Royal Maternity Hospital, Edinburgh*, 25, Charlotte Square, Edinburgh. C. 1884-6. V.-P. 1887-9.

## Elected

- L. 1887 CROUZAT, E., M.D., *Professeur de Clinique d'Accouchements à la Faculté de Médecine de Toulouse*, Toulouse, France.
- 1895 CUFFE, ROBERT, M.R.C.S., L.S.A., Woodhall Spa, Lincoln.
- 1898 CUMMING, GEORGE WILLIAM HAMILTON, M.D.Dur., M.R.C.S., L.R.C.P., Annandale, Torquay, S. Devon.
- 1896 \*DARLEY-HARTLEY, WILLIAM, L.R.C.P.Ed., M.R.C.S.Eng.
- 1895 †DAUBER, JOHN H., M.A., M.B., B.Ch.Oxon., *Assistant Physician Hospital for Women, Soho*, 29, Charles Street, Berkeley Square, W. C. 1900-1.
- F.F. †DAVIES, ELLIS THOMAS, M.D., *Hon. Surgeon Samaritan Free Hospital for Women, Liverpool*, 97, Shaw Street, Liverpool. C. 1901.
- 1900 DAVIES, JOHN STANLEY, M.B., C.M.Glas., 262, Queen's Road, New Cross.
- 1900 DEE, MAURICE V., M.D., F.R.C.S., Chelsea Hospital for Women, Fulham Road, S.W.
- 1895 †DE JERSEY, WALTER BROCK, B.A., M.B., B.Ch.Cantab., Netherton, Waterden Road, Guildford, Surrey.
- 1897 †DELAMOTTE, PETER WILLIAM, M.R.C.P.Edin., M.R.C.S.E., Gresham Lodge, Staines, Middlesex.
- L. 1887 DEWES, FREDERICK JOSEPH, L.R.C.P.Lond., M.R.C.S.E., *Surgeon Captain Madras Army*, care of Messrs. Binney & Co., Madras, India.
- L. F.F.†DINGLE, WILLIAM ALFRED, M.D. St. And., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A., *Surgeon Royal Maternity Charity*, 46, Finsbury Square, E.C. C. 1889-91. V.-P. 1892-4.
- 1887 †DINGLEY, WILLIAM, M.R.C.S., L.S.A., 277, Camden Road, N. C. 1895-7.
- L. 1888 DIRNER, GUSTAV, M.D., 9, Kossuth Utoxa, Buda Pesth, Hungary
- F.F. †DIXON, WILLIAM EDWARD, L.R.C.P.Ed., F.R.C.S.Ed., M.R.C.S., Oulton Lodge, Oulton Broad, Lowestoft.
- 1891 DODD, T. A., M.R.C.S., L.R.C.P.Ed., *Visiting Surgeon Newcastle-on-Tyne Workhouse Hospital*, 4, Eldon Square, Newcastle-on-Tyne.
- 1898 DODSWORTH, FREDERICK CHARLES, L.R.C.P., M.R.C.S., Ingleden House, Gunnersbury.
- F.F. †DOLAN, THOMAS M., M.D.Durh., F.R.C.S.Edin., Horton House, Halifax, Yorkshire. C. 1886-8 & 1892-4. V.-P. 1889-91.
- 1898 †DON, WILLIAM WALTON, M.D.Glas., 466, Edgware Road, W.
- 1895 †DONALD, ARCHIBALD, M.A., M.D.Edin., M.R.C.P.Lond., *Obstetric Physician Royal Infirmary, Manchester*, Platt Abbey, Rusholme, Manchester. C. 1897-9.
- 1897 DONALD, HUGH COLLIGHAN, M.B.Glas. and C.M., 5, Gauze Street, Paisley.
- 1898 DONOVAN, WILLIAM, M.D.Dur., L.R.C.P. & S.Ed., "Glandore," Erdington, Birmingham.

## Elected

- L. 1889 DOUGLAS, RICHARD, M.D., Nashville, Tennessee, U.S.A.
- 1895 †DOVE, PERCY WILLIAM, L.R.C.P., M.R.C.S., 80, Crouch Hill, N.
- 1896 †DOWNES, JOSEPH LOCKHART, M.B., C.M.Glas., 271, Romford Road, E.
- 1898 DOYEN, E., M.D.Paris, 6, Rue Picini, Avenue du Bois de Boulogne, Paris.
- 1898 †DRAKE, A. THOMSON, M.B., R.U.I., 160, Lewisham High Road, S.E.
- F.F. †DRAKE-BROCKMAN, EDWARD FOSTER, F.R.C.S.Eng., L.R.C.P. Lond., 14, Welbeck Street, W.
- L. F.F. DRAPER, JAMES WILLIAM, L.R.C.P.Lond., M.R.C.S.Eng., L.S.A., Almondbury, Huddersfield.
- 1891 DRUMMOND, JAMES, M.D., Westoe, South Shields.
- L. 1885 DUDLEY, EMILIUS CLARKE, A.B., M.D., *Professor of Gynecology Chicago Medical College*, 1617, Indiana Avenue, Chicago, U.S.A.
- F.F. \*DUNDAS, MORDAUNT GEORGE, M.R.C.S., L.S.A.
- 1896 †DUTCH, HENRY, M.D.BruX., L.R.C.P.Lond., 8, Berkeley Street, Berkeley Square, W.
- 1891 †EASTES, THOMAS, M.D., F.R.C.S., 18, Manor Road, Folkestone.  
C. 1897-1900.
- 1890 ECCLES, F. R., M.D., *Professor of Gynecology at the Western University*, Ellwood Place, London, Ontario, Canada.
- 1894 †EDGE, FREDERICK, M.D., B.S., B.Sc.Lond., M.R.C.P.Lond., F.R.C.S.Eng., *Surgeon to the Wolverhampton Hospital for Women, and to the Birmingham and Midland Hospital for Women*, 54, Darlington Street, Wolverhampton.  
C. 1897-9.
- F.F. †ELDER, GEORGE, M.D., *Surgeon to the Samaritan Hospital for Women, Nottingham*, 17, Regent Street, Nottingham.  
C. 1890-2. V.-P. 1897-9.
- 1898 †ELLIOTT, FRANK PERCY, M.B., C.M.Aberd., 113, Grove Road, Walthamstow, N.E.
- 1898 EMERSON, THOS. G., M.D., M.Ch., R.U.I., Wantage, Berks.
- 1894 EMMET, BACHE MCE., M.D., 18, East Thirtieth Street, New York, U.S.A.  
Hon. Loc. Sec.
- L. 1885 ENGELMANN, GEORGE J., M.D., 336, Beacon Street, Boston, U.S.A.
- 1892 ENGLEMAN, FREDK., M.D., Kreuznach, Germany.
- 1900 ENGLISH, T. JOHNSTON, M.D.BruX., 128, Fulham Road, S. Kensington, S.W.
- F.F. ENSOR, EDWIN THOMAS, M.D.Univ. N.Y., L.R.C.P.I., 162, Ladbroke Grove, W.
- L. 1892 ENGSTRÖM, OTTO, M.D., Helsingfors, Finland.
- 1891 FEHLING, PROFESSOR, M.D., 15, Magdeburger Strasse, Halle.

## Elected

- L. 1886 FENGER, CHRISTIAN, M.D., 269, La Salle Avenue, Chicago, Illinois, U.S.A.
- 1894 †FENTON, FREDERICK ENOS, F.R.C.S.E., M.R.C.P. Edin., Langstone, Uxbridge Road, Ealing, w.
- 1896 †FENWICK, BEDFORD, M.D. Durh., M.R.C.P. Lond., *Physician to the Hospital for Women, Soho*, 20, Upper Wimpole Street, w.
- 1893 †FERGUSON, GEO. GUNNIS, M.B., C.M. Glas., Fern-Combe, New West End, Finchley Road, N.W.
- 1895 FERGUSON, JAMES HAIG, M.D., F.R.C.P.E., *Lecturer on Midwifery and Diseases of Women School of Medicine, Edinburgh, Examiner in Midwifery University of Edinburgh, and Royal College of Physicians*, 25, Rutland Street, Edinburgh.
- 1899 FITZGERALD, EDWARD DESMOND, M.R.C.S., L.R.C.P., 10, West Terrace, Folkestone.
- 1900 FLEMING, ALEXANDER JOHN, M.D., M.Ch., R.U.I., 3, Arkwright Road, Hampstead, N.W.
- 1898 FLOYD, THOMAS SARGENT, M.A., M.D. Dublin, 16, Devonshire Road, Cloughton, Birkenhead.
- 1898 FOGERTY, WILLIAM A., M.D., M.Ch., M.A.O., *Surgeon Limerick Hospital*, 67, George Street, Limerick.
- 1898 †FOOTT, RICHARD ERNEST, M.D., M.Ch., R.U.I., Brandon Lodge, Wood Green, N.
- 1891 FORDE, ERNEST S., L.R.C.P. & S. Ed., Dalry, Galloway.
- F.F. †FORDHAM, JOHN W., L.R.C.P. Edin., M.R.C.S. Eng., 78, Mile End Road, E.
- 1898 FRANZ, R. GRANT, M.D., Marburg and Berlin, Schwalbach, Germany.
- 1885 FRASER, GRAEME BISDEE, M.R.C.S., L.S.A., Belvidere, Beech Road, Weston-super-Mare.
- 1885 FULLER, LEEDHAM, M.R.C.S. Eng., L.S.A. Lond., Oatlands, Streatham Hill, S.W.
- F.F. †GAGE-BROWN, CHARLES HERBERT, M.D., C.M. Ed., 85, Cadogan Place, S.W. C. 1898-9.
- 1898 GALE, ARTHUR, M.R.C.S. Eng., L.R.C.P. Lond., Manorgate House, Kingston Hill, Surrey.
- 1895 †GALLOWAY, ARTHUR W., L.R.C.P., M.R.C.S., 79, New North Road, N.
- F.F. †GARDINER, BRUCE HUBERT JOHN, M.D., L.R.C.P. Edin., M.R.C.S., 48, Barry Road, East Dulwich, S.E.
- 1894 †GARDNER, HAROLD BELLAMY, M.R.C.S. Eng., L.R.C.P. Lond., *Anaesthetist Charing Cross Hospital*, 52, Beaumont Street, w. C. 1899.
- F.F. GARDNER, WILLIAM, M.D., *Professor of Gynecology in McGill University*, 109, Union Avenue, Montreal, Canada. V.P. 1887-9.
- 1895 †GEORGE, WM. HOTTEN, M.R.C.S. Eng., L.R.C.P. Ed., 9, Osnaburgh Street, N.W.



## Elected

- 1895 GIFFARD, H. E., M.R.C.S., Denham House, Egham, Surrey.
- L. 1885 GILES, PETER BROOME, M.R.C.S., L.R.C.P., Holne Chase, Bletchley, Bucks.
- 1900 GLENN, JOHN HUGH ROBERT, M.D.Dub., F.R.C.P.I., *Gynaecologist to Mercer's Hospital*, 24, Lower Bagot Street, Dublin.
- 1897 GODFREY, FRANK W. A., M.B.Edin. and C.M., *Hon. Surgeon Scarborough Hospital and Dispensary*, 5, Montpellier Terrace, Scarborough.
- 1891 †GODSON, CLEMENT, M.D., M.R.C.P., *Consulting Physician to the City of London Lying-in-Hospital*, late *Assistant Physician Accch. St. Bartholomew's Hospital*, 82, Brook Street, Grosvenor Square, w.  
C. 1892-4 & 1897-9. Pres. 1895-6. V.-P. 1900-1.
- F.F. GOLDSMITH, GEORGE POCOCK, M.D., 3, Harpur Place, Bedford.  
C. 1891-3.
- L. 1886 GORDON, SAMUEL C., M.D., 157, High Street, Portland, Maine, U.S.A.
- 1891 GOWANS, WILLIAM, M.D.Dur., F.R.C.S.Edin., Westoe House, Westoe, South Shields.
- 1896 †GRANT, WILLIAM FRANCIS, M.D.Edin., 159, Edgware Road, w.
- 1896 GRAY, WILLIAM, M.D. and C.M.Edin., Church Square, West Hartlepool.
- 1891 GREEN, W. O., M.D., 709, 2nd Street, near Chestnut, Louisville, Kentucky, U.S.A.
- 1900 GREER, WILLIAM JONES, F.R.C.S.I., L.R.C.P.I., L.M., D.P.H., 2, Chepstow Road, Newport, Monmouthshire.
- F.F. †GRIFFITH, G. DE GORREQUER, L.R.C.P., M.R.C.S., *late Senior Physician to Hospital for Women and Children, Pimlico*, 34, St. George's Square, s.w., and New Indian Club, Whitehall Gardens, s.w.
- L. 1885 †GRIMSDALE, THOMAS BABINGTON, B.A., M.B.Cantab., M.R.C.S., *Gynaecological Surgeon Liverpool Royal Infirmary*, 29, Rodney Street, Liverpool. Hon. Loc. Sec. C. 1894-6.
- 1898 †GUNTON, GEORGE ANDREW, L.R.C.P.I., L.S.A., 3, Sloane Court, s.w.
- 1885 HACKNEY, JOHN, M.D., M.R.C.S., L.S.A., Oaklands, Hythe, Kent.
- 1895 HALL, ERNEST AMOS, M.D., C.M.Ont., L.R.C.P.Ed., 92, Government Street, Victoria, British Columbia.
- L. 1885 HALL, RUFUS B., M.D., 37, Crown Street, Walnut Hills, Cincinnati, U.S.A.
- L. 1886 HANKS, HORACE TRACY, M.D., 766, Madison Avenue, New York, U.S.A.
- 1898 HANSON, ARTHUR STEPHEN, M.R.C.S., L.R.C.P., Titchfield, Fareham, Hants.
- 1897 †HARLEY, HENRY, M.D., R.U.I., 27, Victoria Road, Battersea Park, s.w.

## Elected

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- 1898 †HARTT, CHARLES HENRY, L.R.C.P.I., L.R.C.S.I., L.M., 14, Croom's Hill, Greenwich, S.E.
- F.F. HASLAM, WM. DOIGE, M.D.Brux., M.R.C.S.Eng., L.S.A., Walpole House, Wallington, Surrey.
- F.F. †HAULTAIN, FRANCIS WM. NICOL, M.D., F.R.C.P.Ed., *Physician for Diseases of Women, Royal Dispensary, Lecturer on Midwifery and Diseases of Women, Edinburgh School of Medicine*, 17, Rutland Street, Edinburgh. Hon. Loc. Sec. C. 1896-8.
- 1889 HAWKES, A. E., M.D.Brux., L.R.C.P. and S.Ed., 22, Abercromby Square, Liverpool.
- L. 1886 HEADLEY, W. BALLS, M.A., M.D., F.R.C.P., 4, Collins Street, Melbourne, Australia. C. 1896-8.
- 1887 \*HEALD, BENJAMIN GREY, L.R.C.P.Ed., L.F.P.S.G.
- F.F. †HEBERT, PAUL ZOTIQUE, M.D., C.M.McGill, L.R.C.P.Lond., 16A, Old Cavendish Street, Cavendish Square, W. C. 1896-8.
- L. 1885 HEIBERG, WILHELM, M.D., *Surgeon to the County Hospital of Copenhagen*, Frederiksberg, Copenhagen.
- 1898 HELME, THOMAS ARTHUR, M.D.Edin., M.R.C.P.Lond., M.R.C.S.Eng., 337, Oxford Road, Manchester.
- L. 1887 HETHERINGTON, GEO. ALBERT, M.D., St. John, N.B., Canada.
- 1891 HILL, J. STONELEY, M.B. and C.M.Edin., 33, Great Charlotte Street, Blackfriars Road, S.E.
- F.F. †HILLS, AUGUSTUS PHILLIPS, M.R.C.S.Eng., Carlton House, 1, Prince of Wales Road, Battersea Park, S.W.
- F.F. †HINE, ALFRED LEONARD, L.R.C.P.Lond., M.R.C.S., L.S.A., Eppingdale, Leytonstone Road, E. C. 1891-2.
- 1898 †HINGSTON, WILLIAM F., M.D., B.A., T.C.D., 215, Evelyn Street, Deptford, S.E.
- L. 1887 HOAG, JUNIUS C., M.D., 4669, Lake Avenue, Chicago.
- F.F. †HODGSON, ROBERT HUGH, M.D.Dur., M.R.C.S.Eng., 204, Rye Lane, Peckham, S.E. C. 1894-7 and 1901. V.-P. 1898-1900.
- 1895 †HOLLAND, C.E., M.B., C.M.Ed., "Airdrie," The Avenue, Kew Gardens, Surrey.
- F.F. †HOLLAND, EDMUND, M.D., M.R.C.P., F.R.C.S., *Physician to the Hospital for Women, Soho*, 1, Titchfield Terrace, North Gate, Regent's Park, N.W. C. 1893-5.
- L. 1885 HOOPER, JOHN WILLIAM DUNBAR, L.R.C.P. and S.Edin., *Surgeon to the Women's Hospital, Melbourne*, 70, Collins Street, East Melbourne.
- 1899 HORNE, ANDREW JOHN, F.R.C.P.I., 94, Merrion Square, Dublin.
- 1898 HOWARD, ARTHUR WALTERS, M.R.C.S., L.R.C.P., Wealdstone, Harrow.
- F.F. †HOWELL, HORACE SYDNEY, M.D., F.R.C.S., 72, Boundary Road, South Hampstead, N.W. C. 1898-9.

## Elected

- 1898 †HUNTER, SAMUEL ROGER, M.D., M.Ch., R.U.I., Lynher House, High Street, Clapham, s.w.
- 1887 HUTCHISON, GEORGE WRIGHT, M.D.Aber., M.R.C.P.Edin., Chipping Norton, Oxon.
- F.F. †ISDELL, FITZGERALD, M.A., M.D.Dub., 189, Shaftesbury Avenue, w.c
- F.F. JACKSON, THOMAS VINCENT, F.R.C.S.Edin., J.P., *Senior Surgeon to the Wolverhampton and Staffordshire General Hospital*, Whetstone House, Waterloo Road South, Wolverhampton. C. 1884-6.
- F.F. †JAMES, W. CULVER, M.D., 15, Marloes Road, Kensington, w. C. 1884-6.
- 1894 †JARDINE, JAMES, M.B.Edin., C.M., 3, Lichfield Gardens, Richmond, Surrey.
- 1888 JELLETT, HENRY, M.D.Dub., M.R.C.P.I., 61, Lower Mount Street, Dublin. Hon. Loc. Sec.
- 1887 †JESSETT, FREDERICK BOWREMAN, F.R.C.S.Eng., *Surgeon to the Cancer Hospital, Brompton*, 23, Brook Street, w. C. 1891-2, 1894-7 and 1901. V.-P. 1898-1900. Pres. 1893.
- L. 1885 JEWETT, CHARLES, M.D., 330, Clinton Avenue, Brooklyn, U.S.A.
- 1897 \*JOHNSTON, G. J. WALDRON, M.D.; R.U.I.
- 1886 JOHNSTON, JOHN, M.R.C.S.Eng., 2, Rocky Hill Terrace, Maidstone.
- L. 1886 JOHNSTONE, ARTHUR W., M.D., Madisonville Road, Cincinnati, Ohio.
- 1891 JOHNSTONE, GEORGE W., L.R.C.P., Government Medical Officer, 3, Battery Road, Singapore.
- 1887 JONES, C. N. DIXON, M.D., 249, East 86th Street, New York, U.S.A.
- 1894 JONES, D. MARINUS, M.D., M.Ch.Edin., Melbourne House, Victoria Road, Aldershot.
- 1899 JONES, EVAN JAMES TREVOR, M.R.C.S., L.R.C.P., Ty-mawr, Aberdare, S. Wales.
- 1895 †JONES, JOHN, L.R.C.P., M.R.C.S., Claremont, Newlands Park, Sydenham, s.e.
- 1893 †JORDAN, JOHN FURNEAUX, M.B., R.U.I., F.R.C.S.Eng., *Surgeon Women's Hospital, Birmingham*, 114, Edmund Street, Birmingham. C. 1899-1901.
- 1885 JOUBERT, CHARLES HENRY, M.B.Lond., F.R.C.S.Eng., *Surgeon Lieut.-Colonel I.M.S., Professor of Midwifery and Obstetric Physician Medical College, Calcutta*, 6, Harrington Street, Calcutta.
- 1895 †KEITH, GEORGE E., M.B., C.M.Ed., 42, Charles Street, Berkeley Square, w. Hon. Sec. 1897-9. C. 1900-1.
- 1894 †KEITH, SKENE, M.B., C.M.Edin., F.R.C.S.E., 42, Charles Street, Berkeley Square, w. C. 1897-9. V.-P. 1900-1.
- L. 1889 KELLOGG, J. H., M.D., Battle Creek, Michigan, U.S.A.

## Elected

- 1868 KELLY, HOWARD A., M.D., Univ. of Pennsylvania, *Professor of Gynecology and Obstetrics in Johns Hopkins University*, 1406, Eutaw Place, Baltimore, Pa., U.S.A.
- 1891 †KEMPSTER, WM. H., M.B.Durh., 1, Albert Bridge Road, Battersea Park, S.W.
- F.F. †KENNEDY, JOHN BLYDESTYN, M.R.C.S.Eng., L.S.A., Stratford Hall, Stratford, E.
- 1898 KERR, JOHN GEORGE DOUGLAS, M.B., C.M.Glas., 6, Royal Circus, Bath.
- 1900 KIDD, FREDERICK WILLIAM, M.D. Dub., *Master of Coombe Hospital, Professor of Midwifery and Gynecology, R.C.S.I.*, 17, Lower Fitzwilliam Street, Dublin.
- L. 1886 KING, ALBERT F. A., M.D., 1315, Mass. Avenue, N.W., Washington, D.C., U.S.A.
- 1898 KINKEAD, RICHARD JOHN, M.D., L.R.C.S.I., *Prof. of Obstetrics, Queen's College, Galway*, Forster House, Galway.
- 1893 KIRKLEY, C. A., M.D., 1105, Jefferson Street, Toledo, Ohio, U.S.A.
- F.F. KNOTT, CHARLES, M.R.C.P.Edin., Liz Ville, Elm Grove, Southsea.
- 1898 LANDAU, L., M.D., *Professor of Gynecology of the University of Berlin*, Berlin. V.-P. 1900-1.
- L. 1886†LAWRIE, JAS. MCPHERSON, M.D., *Physician to the Weymouth Sanatorium*, Greenhill, Weymouth. C. 1894-6. V.-P. 1899-1901.
- 1899 LEA, ARNOLD WILLIAM WARRINGTON, M.D., B.S.Lond., F.R.C.S.Eng., *Assistant to the Professor of Obstetrics, Owens College; Assistant Surgeon to the Clinical Hospital for Women and Children*, Manchester, 274, Oxford Road, Manchester.
- L. F.F. LEBLOND, ALBERT, M.D., *Médecin de Saint-Lazare*, 53, Rue d'Hauteville, Paris.
- 1889 LEIGH, W. W., L.R.C.P.Edin., M.R.C.S.Eng., L.S.A., Glyn Bargoed, Treharris, R.S.O., South Wales.
- L. F.F. LE PAGE, JOHN FISHER, M.D., L.R.C.P.Edin., The Poplars, Cheadle, Cheshire.
- F.F. \*LESLIE, WILLIAM MURRAY, M.D.Edin., C.M., F.R.C.S.E.
- 1899 LEWIS, PERCY GEORGE, M.D.Bru., M.R.C.S., 22, Manor Road, Folkestone.
- 1891 LLOYD, H. J., L.R.C.P.Edin., L.F.P.S.Glas., Tyncoed, Barmouth, North Wales.
- F.F. †LLOYD, SAMUEL, M.D., 60, Bloomsbury Street, Bloomsbury, W.C.
- 1893 LLOYDE, JOHN HY., L.R.C.P. and S.Edin., 6, Harpur Place, Bedford.
- 1895 †LONG, RICHARD PATRICK, L.F.P.S.Glas., L.S.A., 99, Queen's Crescent, Haverstock Hill, N.W.
- F.F. †LOW, RICHARD MARSDEN PILKINGTON, M.B., C.M.Edin., L.R.C.P. and S.Edin., L.M., 70, Philbeach Gardens, S.W. C. 1896-8.
- 1895 †LUCKY, WM. CURRIE, M.D.Aberd., M.R.C.S., Penrose House, Rosslyn Hill, Hampstead, N.W. C. 1901.



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- 1894 LUTAUD, AUGUSTE, M.D. Paris, *Redacteur en Chef du Journal de Médecine de Paris; Médecin Adj. de l'Hôpital St. Lazare, 47, Boulevard Haussmann, Paris.*
- F.F. †LYCETT, JOHN ALLAN, M.D. St. And., M.R.C.P. Edin., *Surgeon Wolverhampton and District Hospital for Women, Gatcombe, Wolverhampton.* Hon. Loc. Sec. C. 1889-91.
- 1899 LYLE, ROBERT PATTON RANKEN, B.A., M.D., B.Ch. Dub., *Lecturer on Midwifery and Diseases of Women and Children, Durham University College of Medicine, 20, Saville Row, Newcastle-on-Tyne.* Hon. Loc. Sec.
- F.F. MACAN, ARTHUR VERNON, B.A., M.B. Dub., M.Ch., M.A.O., F.R.C.P.I., *King's Professor of Midwifery Trinity College; Obstetric Physician Sir P. Dunn's Hospital; Ex-Master of the Rotunda Hospital, Dublin, 53, Merrion Square, Dublin.* V.-P. 1887-8. Pres. 1889. C. 1890-2.
- L. 1885 †MACAN, JAMESON JOHN, M.A., M.D. Cantab., M.R.C.S., Crossgates, Cheam, Surrey. C. 1895-7. V.-P. 1898-1900. Editor, 1899-1901.
- 1899 MCARDLE, JOHN STEPHEN, F.R.C.S.I., *Surgeon to St. Vincent's Hospital, 7, Upper Merrion Street, Dublin.*
- 1898 MACARTNEY, RICHARD, L.R.C.P. & S. Edin., Lisanore, Cinderford, Gloucestershire.
- 1900 MACCORMAC, JOHN SIDES DAVIES, L.R.C.P. & S. Ed., L.R.C.P. & S. Glas., Iveagh House, Belgrave, Leicester.
- 1895 MACDONALD, JAMES, M.D. Ed., Bloxwich, Wallsall, Staffs.
- 1898 †MACDONNELL, ALEXANDER, L.R.C.S. Ed. and L.S.A., 39, Stamford Hill, N.
- 1895 MACGREGOR, ANGUS VALLANCE, M.D. Edin. and C.M., Durham House, Victoria Road, West Hartlepool.
- 1897 MACGREGOR, PETER, F.R.C.S. Ed., Rashcliffe, Huddersfield.
- L. 1889 MACKAY, W. A., M.D. Edin., F.R.C.S. Edin., Huelva, Spain.
- L. 1888 †MACKINTOSH, G. D., L.R.C.P.I., L.M. Ed., Fairford House, Lower Kennington Lane, S.E.
- 1898 †McMANUS, LEONARD STRONG, M.D., Westwood House, St. John's Hill, S.W.
- 1892 McMURTRY, L. S., M.D., 1912, Sixth Street, Louisville, Kentucky, U.S.A.
- F.F. †MACNAUGHTON-JONES, H., M.D., M.Ch., Q.U.I., M.A.O., F.R.C.S.I. and Edin., *late Examiner in Midwifery Royal University Ireland, and Professor of Midwifery Queen's College, Cork, 131, Harley Street, W.* C. 1890-2 and 1900-1. V.-P. 1895-7. Pres. 1898-9.
- 1897 †MACNAUGHTON-JONES, H. M., M.B., B.Ch., R.U.I., L.R.C.P., M.R.C.S., 13, Sandwell Mansions, West End Lane, N.W. Editor, 1900-1.
- 1894 \*MADDIN, JOHN WALSEY, Junr., M.D.
- 1888 MANTON, WALTER PORTER, M.D., 32, Adams Avenue, W., Detroit, Mich., U.S.A.

## Elected

- 1887 MARLEY, HENRY FREDERICK, M.R.C.S.E., L.R.C.P., L.S.A., L.M.,  
The Nook, Padstow, Cornwall.
- 1895 MARTIN, CHARLES, M.B., C.M.Ed., Dagenham House, Newton  
Abbot, South Devon.
- 1891 †MARTIN, CHRISTOPHER, M.B.Edin., C.M., F.R.C.S.Eng., *Surgeon  
Birmingham and Midland Hospital for Women*, Cleveland House,  
George Road, Edgbaston, Birmingham.  
Hon. Loc. Sec. C. 1897-9.
- 1896 MATTICE, RICHARD ISA, M.D.McGill, L.R.C.P.Lond., Omaha,  
Nebraska, U.S.A.
- 1895 †MAY, EDWIN HOOPER, M.D. St. And., F.R.C.S., Tottenham High  
Cross, N.
- 1896 MAYBURY, LYSANDER, M.D., R.U.I., M.Ch., M.R.C.S.Eng., 9,  
Hampshire Terrace, Southsea.
- 1891 MEARNS, WILLIAM, M.A., M.D., *Physician Children's Hospital,  
Gateshead-on-Tyne*, 22, Bewick Road, Gateshead-on-Tyne.
- 1891 MEEK, H., M.D., 331, Queen's Avenue, London, Ontario, Canada.
- 1887 MENDES DE LEON, M.A., M.D., Sarphati Straat, 1H, Amsterdam.  
C. 1892.
- L. 1886 MERRIMAN, HENRY P., M.D., 2239, Michigan Avenue, Chicago,  
U.S.A.
- 1896 METCALFE, JAMES, M.D.Brux., L.R.C.P. and S.Edin., *Surgeon to St.  
Catherine's Home for Cancer, Bradford*, 8, Heaton Grove, Bradford,  
Yorks.
- 1891 MICHIE, H., M.B.Aber., C.M., *Surgeon to the Samaritan Hospital,*  
27, Regent Street, Nottingham.  
C. 1894-6.
- 1895 †MILLER, FREDK. R., M.D.Brux., L.R.C.P.Lond., 19, Harley Street, W.
- L. 1886\* MILLER, DE LASKIE, M.D., *Professor of Obstetrics Rush Medical  
College.*
- 1896 MINCHIN, P. DUNDAS, L.R.C.P. and S.Edin., Oldcroft, Godalming,  
Surrey.
- 1892 MOLSON, JOHN CAVENDISH, L.R.C.P., 10, Walsingham Terrace, West  
Brighton.
- 1896 MORGAN, THOMAS HOWARD, M.D., F.R.C.S.Ed., Gympie, Queens-  
land, Australia.
- 1887 MORISON, ALBERT EDWARD, M.B., C.M.Ed., F.R.C.S.Edin.,  
Wellington Road, West Hartlepool.
- 1891 MORISON, J. RUTHERFORD, M.B., F.R.C.S., *Surgeon Newcastle-on-  
Tyne Infirmary*, 14, Saville Row, Newcastle-on-Tyne.  
C. 1894-6.
- 1894 MORLAND, CHARLES HENRY DUNCAN, M.B., B.S.Durh., F.R.C.S.,  
Swatow, China.
- 1898 MORRIS, RICHARD JOHN, L.S.A., M.D.Heidelberg, Stone Hall  
Glandore, Leap, co. Cork.
- F.F. †MORTON, THOMAS, M.D.Lond., M.R.C.S., L.S.A., *ex-President of  
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C. 1889-90 and 1899-1901.

## Elected

- 1898 †MOSSE, HERBERT RYDING, M.D., M.R.C.S.Eng., Hobart House, Clapham Common, s.w.
- F.F. †MOULLIN, J. A. MANSELL, M.A., M.B.Oxon., M.R.C.P., *Physician to the Hospital for Women, Soho, Physician for Diseases of Women to the West London Hospital, 80, Porchester Terrace, Hyde Park, w.*  
C. 1884-6. Hon. Sec. 1887-8. V.-P. 1889-91. Libr. 1892.  
Treas. 1893-1900. President 1901.
- L. 1885 MUNDE, PAUL F., M.D., *Professor of Gynæcology at the New York Polyclinic, and at Dartmouth College, 20, West Forty-Fifth Street, New York, U.S.A.*  
V.-P. 1886-7.
- 1900 MURPHY, J. KEOGH, M.A., M.D., B.C.Camb, 35, Princes Square, Bayswater.
- 1896 MURRAY, CHAS. F. K., M.D., R.U.I., F.R.C.S., Kenilworth, Cape Town, S. Africa.
- 1885 MURRAY, ROBERT MILNE, M.A. St. And., M.B.Edin., F.R.C.P.Edin., F.R.S.E., *Assistant Physician Maternity Hospital; Lecturer on Midwifery and Gynæcology Edinburgh School; Physician for Diseases of Women to the Western Dispensary; President Edinburgh Obstetrical Society, 11, Chester Street, Edinburgh.*  
C. 1886-8. V.-P. 1899-1901.
- 1891 MURRAY, WILLIAM, M.D., F.R.C.P., *Consulting Physician Newcastle-on-Tyne Hospital for Sick Children, 9, Ellison Place, Newcastle-on-Tyne.*
- F.F. MUTCH, F. ROBERTSON, M.D., C.M.Aberd., "Strathgairn," Goldsmith Street, Nottingham.
- 1891 NAPIER, A. D. LEITH, M.D., M.R.C.P.Lond., F.R.S.Edin., *late Physician Royal Maternity Charity of London; Examiner in Midwifery and Gynæcology, Apothecaries' Hall, General Hospital, Adelaide, South Australia.*  
C. 1892. Hon. Sec. 1893-4. Editor 1894-6. V.-P. 1895-7.
- 1889 †NAUMANN, J. C. FRANCIS, M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng., *Physician Italian Hospital, 125, Gower Street, w.c.*
- 1894 †NEATBY, EDWIN A., M.D.Brux., L.R.C.P.Lond., 19, Upper Wimpole Street, w.
- 1891 NEDWILL, COURTNEY, M.D., R.U.I., M.R.C.S., Christchurch, Canterbury, New Zealand.
- L. 1886 NELSON, DANIEL THURBER, M.D., 2400, Indian Avenue, Chicago, U.S.A.
- L. FF. †NETHERCLIFT, WILLIAM HENRY, F.R.C.S.Ed., Piccadilly Club, Piccadilly, W.
- L. F.F. NEUGEBAUER, FRANZ, M.D., *Directeur de l'Hôpital Evangelique, Leszno, 33, Warsaw, Russia (Poland).*  
V.-P. 1887-9.
- 1898 †NEVILLE, THOS., M.D., R.U.I., 123, Sloane Street, s.w.
- 1896 NEWNHAM, WILLIAM HARRY CHRISTOPHER, M.A., M.B.Camb., M.R.C.S., *Physician Accoucheur Bristol General Hospital, Chandos Villa, Queen's Road, Clifton.*  
C. 1898-1900.
- 1898 NOBLE, CHARLES P., M.D.Maryland, 1509, Locust Street, Philadelphia, Pa., U.S.A.!

## Elected

- 1896 †O'BRYEN, JAMES WHEELER, M.D.Vermont, L.R.C.P. and S.Ed.,  
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- L. 1889 †O'CALLAGHAN, ROBERT, L.R.C.P., F.R.C.S.I., *late Surgeon Carlrow  
Infirmary and Surgeon Chelsea Hospital for Women*, 137, Harley  
Street, w. C. 1891-3.
- 1898 O'CONNOR, WILLIAM MOYLE, M.A., M.D.Dub., Lyndhurst, Cargate,  
Aldershot.
- 1885 O'DONNELL, THOMAS J., L.K.Q.C.P.I., L.M., L.R.C.S.I., *Surgeon  
Major Army*, Oorgaum, Mysore State, India.
- 1898 O'HAGAN, PATRICK FRANCIS, L.R.C.P. & S.E., Tower House,  
London Road, Croydon.
- 1895 \*OLIVER, FRANKLIN HEWITT, L.R.C.P.Lond., L.S.A.
- 1894 †OLIVER, JAMES, M.D., M.R.C.P.Lond., F.R.S.Edin., *Physician to  
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C. 1896-98. V.-P. 1900-1.
- 1891 OLIVER, THOS., M.A., M.D., F.R.C.P., *Professor of Physiology  
University of Durham, Physician Newcastle-on-Tyne Infirmary*,  
7, Ellison Place, Newcastle-on-Tyne. C. 1892-4.
- 1898 OPPENHEIMER, HEINRICH, M.D.Heidelberg, M.R.C.P.Lond., 63,  
Finsbury Pavement, e.c.
- L. 1889 OSTROM, H. J., M.D., 42, West 48th Street, New York, U.S.A.
- F.F. †PADMAN, JOHN, M.R.C.S.Eng., 22, Bloomsbury Square, w.c.
- L. 1888 PARKINSON, J. TAYLOR, M.D., Brook View, Crystal Brook, South  
Australia.
- 1898 †PARSONS, JOHN INGLIS, M.D., M.R.C.P., *Physician to the Chelsea  
Hospital for Women*, 3, Queen Street, Mayfair, w. C. 1900-1.
- 1898 PATTISON, EDWARD SETON, M.R.C.S., L.R.C.P.Ed., Granville House,  
Fulham Park, s.w.
- 1898 PEARSON, CHARLES YELVERTON, M.D., M.Ch., 1, Sidney Place, Cork.  
Hon. Loc. Sec.
- 1899 \* PECK, FRANCIS SAMUEL, M.R.C.S., L.R.C.P., *Major Indian Medical  
Service*, 6, Harrington Street, Calcutta.
- 1891 PHILIPSON, Professor Sir G. H., M.A., M.D.Cantab., D.C.L., F.R.C.P.,  
*Professor of Medicine University of Durham, Senior Physician  
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Tyne.
- L. F.F. PINARD, ADOLPHE, M.D., *Professeur à la Faculté, Accoucheur de Lari-  
boisière*, 11, Rocquepine, Paris. V.-P. 1900-1.
- 1895 PLOWMAN, T. A. BARRETT, M.R.C.S., L.R.C.P., Greenway, North  
Curry, Taunton.
- L. 1885 POLK, WILLIAM M., M.D., *Ex-President New York Obstetrical Society*,  
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- 1886 †POPE, HARRY CAMPBELL, M.D.Lond., F.R.C.S., 6, Ashchurch Grove,  
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## Elected

- 1891 †POULTER, ARTHUR REGINALD, M.R.C.S., L.R.C.P., 4, Gordon Mansions, Gower Street, W.C.
- 1898 PRINGLE, GEORGE LORAIN KERR, M.D., C.M.Ed., King's Square, Bridgwater, Somerset.
- F.F. †PURCELL, FERDINAND ALBERT, M.D., M.Ch., R.U.I., M.R.C.S., L.M.Eng., *Surgeon to the Cancer Hospital, Brompton*, 7, Manchester Square, W. C. 1888-9, 1893-5.
- L. F.F. PUREFOY, RICHARD DANCER, M.D., T.C.D., F.R.C.S.I., *Obstetric Surgeon Adelaide Hospital, Master of the Rotunda Hospital*, 20, Merrion Square, Dublin. C. 1884-6. V.P. 1899-1901.
- 1895 †PUTSEY, WILLIAM H., M.D.Dur., M.R.C.S., *Fleet Surgeon (retired) R.N., Medical Registrar South London Hospital for Women*, Junior United Service Club, S.W.
- 1887 RAE, GEORGE A., L.R.C.P. and S.Ed., 1, Outram Terrace, Stoke, Devonport.
- 1894 †RAMSAY, FRANK WINSON, M.D., B.S.Durh., F.R.C.S.Ed., Jesmond Dene, Bournemouth. C. 1900-1.
- L. F.F. RASCH, ADOLPHUS A. F., M.D., M.R.C.P., *late Physician for Diseases of Women and Children to the German Hospital, London*, Blumenstrasse, 5, Halle à Saale, Germany. C. 1891-3. V.-P. 1895-6.
- F.F. RAWLINGS, JOHN ADAMS, M.R.C.P.Edin., M.R.C.S.Eng., *Physician to the Swansea Hospital*, Preswylfa, Swansea. C. 1888-9.
- 1898 †REDFERN, JOHN J., M.D., M.A.O., *Surgeon to the Croydon General Hospital*, Croindene, Wellesley Road, Croydon.
- L. 1887 REED, CHARLES A. L., M.D., *Professor of Gynecology and Abdominal Surgery at the Cincinnati College of Medicine and Surgery, and Surgeon to the Cincinnati Free Surgical Hospital for Women*, Cincinnati, Ohio, U.S.A.
- F.F. REID, W. LOUDON, M.D.Glas., F.F.P.S.Glas., *Professor of Midwifery and Diseases of Women and Children, Anderson's College, Glasgow, Physician to Dispensary for Diseases of Women, Western Infirmary*, 7, Royal Crescent, Glasgow. C. 1888-9. V.-P. 1896-8.
- 1898 RICE, GEORGE, M.D.Dur., 46, Friar Gate, Derby.
- F.F. \*RICHARDSON, JOHN HUMPHREY HOWARD, M.R.C.S., L.S.A.
- 1887 RICHMOND, THOMAS, L.R.C.P.E., L.F.P.S.G., 22, Holyrood Crescent, W., Glasgow.
- L. 1888 RICKETTS, E. S., M.D., 93, East Fourth Street, Cincinnati, Ohio, U.S.A.
- L. F.F. ROBERTS, D. LLOYD, M.D., F.R.C.P., F.R.S.Edin., *Physician to St. Mary's Hospital, Manchester, and Lecturer on Clinical Midwifery and the Diseases of Women in Owens College*, 11, St. John Street, Manchester. C. 1884. V.-P. 1886-8.
- F.F. †ROBERTS, THOMAS, L.S.A.Lond., 2, Selborne Gardens, York Road, Ilford, Essex.
- L. F.F.†ROBERTSON, A. MILNE, M.D.Edin., Gonville House, Alton Road, Roehampton, S.W.

## Elected

- 1898 †ROBINSON, MALACHI J., M.D., M.Ch., R.U.I., 257, Essex Road, Canonbury, N.
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